# Issue Brief

# AIDS In the Workplace: Municipal Policies Affecting Public Safety Personnel

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## INTRODUCTION

"AIDS" stands for Acquired Immune Deficiency Syndrome, a disease which breaks down the immune system. This breakdown leaves the body vulnerable to a variety of unusual, life-threatening illnesses. It is these diseases, not the AIDS virus itself, which can result in death. AIDS has been fatal in more than 50 percent of the reported cases. The most common illnesses occuring in people with AIDS are Pneumocystis carinii pneumonia and Kaposi's sarcoma, a form of skin cancer. (1)

AIDS is caused by a virus, known as HIV, that attacks the T-cells in the immune system. Infection with the AIDS virus does not necessarily result in AIDS or AIDS Related Conditions (ARC). However, the AIDS virus must be present in the system for AIDS to occur. At present there is no effective treatment or vaccine against the disease, and many persons infected with the virus are not aware that they are carrying it. (2)

Medical authorities who have studied thousands of cases of AIDS for several years agree that AIDS is spread in only four ways: by sexual intercourse with a person infected with the AIDS virus; by the sharing of IV drug needles with an infected person; by the injection of contaminated blood products, which can occur through blood tranfusions; and by childbirth (a pregnant infected woman can pass the virus to the baby). In short, AIDS is not easily spread from person to person, and certainly is never spread by casual contact. (3)

Many symptoms associated with AIDS are also seen in common, minor illnesses, such as colds, bronchitis, and stomach flu.

However, in AIDS these symptoms are usually persistent or recurrent. The general symptoms associated with AIDS may include:

- unexplained, persistent fatigue;
- unexplained fever, shaking chills, or drenching night sweats lasting longer than several weeks;
- unexplained weight loss greater than 10 pounds;
- swollen glands in the neck, armpits or groin lasting more than two months;
- pink or purple flat or raised blotches or bumps occurring on or under the skin;
- persistent white spots or unusual blemishes in the mouth;
- persistent diarrhea and loss of appetite; and
- persistent dry cough which lasts too long to be caused by the common cold. (4)

The AIDS virus may also infect the brain or central nervous system, resulting in such symptoms as thinking or memory disorders and coordination problems, sometimes referred to as AIDS-related dementia.

## THE IMPACT OF AIDS

The AIDS virus, HIV, has infected between one to one and one-half million people throughout the United States. By 1991, this figure is expected to increase to over four

million. Figures provided by the Centers for Disease Control (CDC), located in Atlanta, Georgia, indicate that within seven years of infection with the HIV virus, 35 percent of those carrying the virus develop AIDS, while an additional 25 percent show signs of health deterioration such as swollen lymph nodes, night sweat, and diarrhea. (5)

The disease in the United States has shown to be concentrated in major cities, among gay men and IV drug users. But that pattern is progressively changing. In 1989, incidence of AIDS rose nearly four times as fast in the nation's smallest cities as in its largest ones. And while the number of new cases rose by 11 percent among gay males, it increased by approximately 36 percent among heterosexuals and newborns. (6)

Officials in small towns across the U.S. must take advantage of informational and educational sources available from other localities, so their response can be informed, thus minimizing fear and inappropriate actions.

According to the Panos Institute, the disease is seen in the United States as a phenomenon associated with social and developmental problems. Approximately 84 percent of women with AIDS in New York City are black or Hispanic. AIDS is already the largest single cause of death in New York City among black and Hispanic women aged 25 to 29. Cities with large minority populations such as New York, Houston, Washington, D.C., Miami, Newark N.J., Los Angeles and others have developed AIDS education programs designed to reach minority populations. (7)

(For more information on geographic, racial, gender and age related statistics, see Appendix A.)

## DISCRIMINATION AND THE LAW

People with AIDS and those infected with the HIV virus experience discrimination at many levels of our society. Discrimination impairs the active identification of infected individuals, hampers prevention activities and decreases access to care. However, discrimination appears to decrease with increased information and education. Education reduces fear among health care workers, fellow employees and the general public. As fear is reduced so is inappropriate behavior and discrimination.

Section 504 of the federal Vocational Rehabilitation Act of 1973, has been interpreted -- by the Supreme Court decision in the School Board of Nassua County v. Gene H. Arline and the U.S. Department of Justice -- to protect the rights of people with Aids, HIV infection and those perceived to be infected. The protections extend to employment, housing and other public accommodations if the organization receives federal funds. (8)

Every state has some type of a law protecting the physically disabled or handicapped from discrimination. About one-half of the states have taken formal action to extend these protections to HIV infected persons. At least 18 states also extend protections to persons who are perceived to be HIV infected. (9)

Confronting discrimination is the foundation for preventing the spread of HIV infection and managing patient needs. To date, the responsibility for limiting discrimination has been left to the states and local governments, primarily because there is no specific federal AIDS discrimination law, except for the provisions of Section 504 which has minimal enforcement powers. (10) (Note Table 1, Federal Laws Relating to AIDS, located on the following page.)

TABLE 1

# FEDERAL LAWS RELATING TO AIDS

| Federal Law | Enacted | Key Provisions |
|---|---|---|
| PL 100-259 Civil Rights Restoration Act of 1987 | 3/22/88 | Amended Vocational Rehabilitation Act of 1973 to protect people with AIDS and HIV from employment discrimination. |
| PL 100-430 Fair Housing Amendments Act of 1988 | 9/13/88 | Amended Fair Housing Act to include AIDS and HIV infection as a protected class under antidiscrimination provisions and authorized new enforcement procedures within the Department of Housing and Urban Development. |
| PL 100-436 Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 1989 | 10/1/88 | Required District of Columbia to repeal its anti-testing AIDS insurance law or all federal funds would be withheld. |
| PL 100-471 The Purchase of Drugs for AIDS Treatment | 10/4/88 | Authorized the appropriation of $15 million to the states to fund AIDS treatment drugs. |
| PL 100-505 Abandoned Infants Assistance Act of 1987 | 10/18/88 | Provided for grants to local jurisdictions to train foster care and counseling personnel to deliver services to at-risk pregnant women. |
| PL 100-607 Health Omnibus Extension Act of 1988 | 11/4/88 | For fiscal years 1989 and 1990, authorized the appropriation of $100 million for allotments to states for home- and community based AIDS services; $165 million for allotments to states for AIDS public information activities; and $100 million for state grants for HIV counseling and anonymous testing. |
| PL 100-690 Omnibus Drug Initiative Act of 1988 9/13/88 | 11/18/88 | Authorized National Institute of Drug Abuse payments to states for AIDS prevention among IV drug users. Established guidelines for compliance in AIDS counseling and testing programs. |

Source: A Policymaker's Guide on AIDS, Appendix A, by Mona Rowe and Caitlin Ryan.

## AIDS TESTING AND CONFIDENTIALITY -- A WORKPLACE ISSUE

Much of the legal controversy surrounding AIDS focuses on testing individuals for the disease. (11) Confidentiality involves the need to balance an individual's legal right to privacy with the public's right to protect its health. In terms of HIV infection many public health officials believe that a person's willingness to be counseled, tested and treated is directly related to three important questions: a) who will have access to the information? b) what information will they have access to? and, c) why does the public need to know this information? (12)

Employees in public health and public safety (police officers, fire fighters, emergency medical technicians, doctors and others who have a higher risk of exposure to the disease because of frequent contact with body fluids) insist that knowledge of who has the disease is vital to help protect them from infection. On the other hand, civil rights advocates argue that, regardless of the expressed reason for testing, the end result will be discrimination against those who test positive for the HIV antibodies. (13)

Mandatory screening programs may not be possible in many states under existing statutes. Laws in California, Washington, D.C., New York, Wisconsin, and Massachusetts, for example, prohibit testing without the informed consent of the subject. In addition, the right to refuse testing may be legally viable if it is argued that disclosure of results could have serious negative consequences on such things as insurance benefits, employment opportunities or family relations. (14)

## ISSUES FOR PUBLIC SAFETY EMPLOYEES

Debate is likely to continue on the issue of how police, fire, and other local public health and safety personnel can best protect themselves from AIDS while continuing to serve their communities. Although health officials estimate that the chances a rescue worker will contact AIDS from an accident victim are less than one percent, this additional risk on the already stressful lives of rescue workers has caused many public safety labor unions to lobby for the adoption of stringent operating procedures. (15)

Clearly, the risk presented to public safety employees varies according to their role. Experts suggest that fire fighters and emergency medical technicians come into contact with body fluids during 50 percent of all responses, while that number for police is between 20 & 30 percent. (16)

Fire fighting, police, and other emergency work has always been risky; AIDS, in effect, is another risk. And when public safety personnel encounter a risk, the traditional response has been to develop a technique to handle it. In this case, preventive measures and procedures are recommended to reduce the risk of transmission.

The recommended precautions (from the federal Centers for Disease Control) which some fire and police departments have implemented consist of, among other things: wearing rubber gloves and protective clothing, following proper cleanup and disposal procedures, and preventing exposure to body fluids. (17)

## THE MOST IMPORTANT ASPECTS THAT MUST BE INCLUDED IN A AIDS POLICY FOR PUBLIC SAFETY EMPLOYEES

When emergency medical and public safety workers encounter body fluids under uncontrolled, emergency circumstances, in which differentiation between fluid types is difficult if not impossible, they should treat all body fluids as potentially hazardous. All patients should be assumed to be infectious for HIV and other blood-born pathogens.

1) **Handling and disposal of sharp objects: All sharp objects must be handled with extraordinary care.**

2) **Damaged skin protection: Personnel must cover all areas of abraded, lacerated, chapped, irritated or otherwise damaged skin with adhesive dressings.**

3) **Handwashing: Hands and other exposed skin should be washed immediately if contaminated with body fluids.**

4) **Gloves: Disposable latex gloves must be worn at all emergency situations.**

5) **Respiratory Assistance Equipment: Pocket masks and bag-valve masks must be readily available to all emergency personnel.**

6) **Goggles, Masks and Gowns: Must also be readily available to all emergency personnel.**

7) **Cleaning, disinfecting and sterilizing: There must be policies on the cleaning of soiled clothing and the disinfecting and sterilizing of equipment and surfaces contaminated with body fluid.**

8) **Cleaning and decontaminating spills of blood: There must policies on the proper clean up of spills of blood.**

9) **Educate personnel about AIDS: There should be a policy on educating all public safety personnel about AIDS.**

10) **Documentation of Incident: There should be a policy for reporting HIV exposures.**

11) **Testing of HIV exposed personnel.**

Source: These guidelines on AIDS for public safety personnel were taken from a brochure by the Department of Occupational Health and Safety and adopted by the International Association of Fire Fighters.

Fire fighters, emergency medical technicians, paramedics, and other emergency response personnel face numerous unique circumstances where they are at risk for exposure to blood, body fluids, and other potentially infectious materials. Their awareness and active protection against infectious diseases are vital to their own health and to the community they serve. (18)

## THE IMPACT IN CITIES

City governments find themselves on the front line in responding to the AIDS epidemic. Traditionally, local governments have taken responsibility for public health concerns in the following ways:

- **Establishing local task forces;**

- **Directing city ordinances to protect both the rights of the individuals and the rights of the public;**

- **Identifying and supporting community leadership;**

- **Coordinating health care and support services; particularly for patients in public facilities; and,**

- **Developing educational strategies through already existing agencies and organizations.**
  (See Appendix D for basic principles in formulating policy.)

As the AIDS epidemic continues to make demands at all levels of government, the response of municipal governments needs to include:

- **providing local leadership in establishing policy;**

- **supporting the educational efforts of community based organizations;**

- **establishing and coordinating comprehensive continuum of care programs at the local level for all persons infected with HIV; and**

- **creating on-going resources at the local level.**(19)
  (See Appendix B)

The National League of Cities updated its National Municipal Policy on November 29, 1989, to emphasize the critical role that federal, state and local government officials should play to reduce discrimination against HIV positive persons and the transmission of AIDS itself. (See Appendix E)

## THE RESPONSIBILITY OF STATE AND LOCAL POLICYMAKERS

Because state and local governments play a key role in protecting public health, including the control of epidemics, the policymaker's role becomes even more important. Perhaps the most important role is one of leadership. This involves:

- Defining the state or local government's mission, objectives and priorities in terms of managing the AIDS epidemic.

- Enunciating the policy of caring for those suffering from disease as well as for friends, family and involved citizens.

- Ensuring that consistent and coherent policies are developed and coordinated at the state and local level.

- Planning for the future and being aware of emerging issues and trends. Mobilizing the citizenry and the private sector.

- Developing appropriate policies and programs for state employees that will set a standard for other employees in the state.

- AIDS will affect a variety of public decisions by becoming another significant variable in the decision making process. This also means other special populations. Thus the policymakers will need to:

    1) Establish priorities among a variety of pressing health policy and financing issues.

    2) Coordinate and involve a wide variety of state and local agencies.

3) **Balance the needs of a variety of advocacy groups with strong concerns about AIDS-related issues.**

Source: These guidelines were taken from A Policymaker's Guide on AIDS, by Mona Rowe and Caitlin Ryan.

## CONCLUSION

The public safety system of today must confront and keep abreast of the AIDS problem. City officials will be confronted with making decisions involving moral, economic and physiological well being of its employees. A city who has a public safety employee who tests positive for HIV, whether because of a workplace exposure or not, must realize that its course of action in handling the problem will affect other employees and their families as well as the affected party.

Cities must also be aware of some other important issues such as discrimination, confidentiality, testing, financing, research, economics, surveillance and public health control. It will begin with a strong working knowledge of AIDS as a disease. This is why it is important for city leaders to adopt a public safety AIDS policy, to protect and assist its employees.

## END NOTES


1. Municipal AIDS Policies and Programs, League of California Cities, July 1989, p. 3.

2. "AIDS LIFELINE," a brochure by the San Francisco AIDS Foundation, September 1989.

3. "AIDS in the Workplace," a brochure by the San Francisco AIDS Foundation, August 1987.

4. "AIDS LIFELINE," a brochure by the San Francisco AIDS Foundation, September 1989.

5. Jeff Glenney, "AIDS: A Crisis in Confidentiality," Southern California Law Review, September 1989, p. 1704-1705.

6. "AIDS The Next Ten Years," Newsweek, June 25, 1990, p. 21.

7. Mark S. Kaplan, "AIDS: Individualizing a Social Problem," Society, January/February 1990, p. 4.

8. Mona Rowe & Caitlin Ryan, A Policymaker's Guide on AIDS, The Intergovernmental Health Policy Project The George Washington University, 1989, p. 13-14.

9. Ibid.

10. Ibid., p. 15.

11. Kenneth Smith, "AIDS and Municipal Employees," Alabama Municipal Journal, January 1988, p. 16.

12. Mona Rowe & Caitlin Ryan, A Policymaker's Guide on AIDS, The Intergovernmental Health Policy Project The George Washington University, 1989, p. 16.

13. Kenneth Smith, "AIDS and Municipal Employees," Alabama Municipal Journal, January 1988, p. 16.

14. Dana Eser Hunt, Ph.D., AIDS in Probation and Parole, June 1989, p. 27.

15. Public Technology Inc., The Urban Consortium, Local Government & AIDS, A Special Report With Case Studies, 1988, p. 16.

16. Ibid.

17. Mike Velasquez & Marilyn Mitchell, "Emergency Response To Questions on AIDS," Fire Engineering, May 1988, p. 46.

18. Edward M. Wall, Federal Emergency Management Agency United States Fire Administration, (a letter to all emergency response agencies), December 1989.

19. Mona Rowe & Caitlin Ryan, A Policymaker's Guide on AIDS, The Intergovernmental Health Policy Project The George Washington University, p. 11.

# A P P E N D I C E S

## Table 1. AIDS cases and annual rates per 100,000 population, by state, reported July 1988 through June 1989, July 1989 through June 1990; and cumulative totals, by state and age group, through June 1990[1]

| State of residence | July 1988-June 1989 | | July 1989-June 1990 | | Cumulative totals | | |
|---|---|---|---|---|---|---|---|
| | No. | Rate | No. | Rate | Adults/adolescents | Children < 13 years old | Total |
| Alabama | 224 | 5.4 | 204 | 4.9 | 736 | 17 | 753 |
| Alaska | 14 | 2.5 | 31 | 5.4 | 91 | 2 | 93 |
| Arizona | 264 | 7.3 | 377 | 10.1 | 1,166 | 7 | 1,173 |
| Arkansas | 79 | 3.3 | 117 | 4.8 | 326 | 6 | 332 |
| California | 5,721 | 19.9 | 6,967 | 23.8 | 26,528 | 185 | 26,713 |
| Colorado | 344 | 10.1 | 384 | 11.1 | 1,385 | 8 | 1,393 |
| Connecticut | 424 | 13.0 | 434 | 13.3 | 1,624 | 53 | 1,677 |
| Delaware | 82 | 12.4 | 83 | 12.5 | 265 | 4 | 269 |
| District of Columbia | 541 | 87.7 | 531 | 86.5 | 2,276 | 29 | 2,305 |
| Florida | 3,170 | 25.2 | 4,037 | 31.3 | 11,714 | 327 | 12,041 |
| Georgia | 1,001 | 15.5 | 1,213 | 18.4 | 3,636 | 42 | 3,678 |
| Hawaii | 114 | 10.2 | 195 | 17.2 | 548 | 2 | 550 |
| Idaho | 20 | 2.0 | 23 | 2.3 | 63 | 2 | 65 |
| Illinois | 1,060 | 9.1 | 1,243 | 10.7 | 4,054 | 59 | 4,113 |
| Indiana | 239 | 4.3 | 273 | 4.9 | 840 | 10 | 850 |
| Iowa | 57 | 2.0 | 50 | 1.8 | 184 | 3 | 187 |
| Kansas | 94 | 3.8 | 132 | 5.2 | 376 | 3 | 379 |
| Kentucky | 109 | 2.9 | 146 | 3.9 | 404 | 5 | 409 |
| Louisiana | 430 | 9.5 | 669 | 14.7 | 1,939 | 34 | 1,973 |
| Maine | 43 | 3.6 | 69 | 5.7 | 188 | 2 | 190 |
| Maryland | 612 | 13.2 | 877 | 18.7 | 2,559 | 61 | 2,620 |
| Massachusetts | 757 | 12.8 | 819 | 13.8 | 2,876 | 61 | 2,937 |
| Michigan | 508 | 5.5 | 529 | 5.7 | 1,673 | 26 | 1,699 |
| Minnesota | 173 | 4.0 | 173 | 4.0 | 702 | 8 | 710 |
| Mississippi | 144 | 5.4 | 214 | 8.0 | 506 | 7 | 513 |
| Missouri | 381 | 7.4 | 562 | 10.8 | 1,538 | 10 | 1,548 |
| Montana | 12 | 1.5 | 16 | 2.0 | 46 | — | 46 |
| Nebraska | 40 | 2.5 | 42 | 2.6 | 150 | 2 | 152 |
| Nevada | 137 | 12.9 | 175 | 16.1 | 521 | 5 | 526 |
| New Hampshire | 47 | 4.2 | 52 | 4.6 | 165 | 4 | 169 |
| New Jersey | 2,376 | 30.5 | 2,245 | 28.6 | 8,906 | 237 | 9,143 |
| New Mexico | 76 | 4.8 | 104 | 6.5 | 288 | 2 | 290 |
| New York | 6,417 | 35.9 | 7,720 | 43.1 | 30,096 | 702 | 30,798 |
| North Carolina | 367 | 5.6 | 514 | 7.7 | 1,387 | 27 | 1,414 |
| North Dakota | 6 | 0.9 | 6 | 0.9 | 19 | — | 19 |
| Ohio | 532 | 4.9 | 569 | 5.3 | 1,946 | 32 | 1,978 |
| Oklahoma | 157 | 4.7 | 212 | 6.4 | 618 | 10 | 628 |
| Oregon | 197 | 7.2 | 277 | 10.0 | 843 | 5 | 848 |
| Pennsylvania | 1,026 | 8.6 | 1,147 | 9.6 | 3,854 | 67 | 3,921 |
| Rhode Island | 86 | 8.7 | 93 | 9.3 | 330 | 7 | 337 |
| South Carolina | 257 | 7.3 | 348 | 9.8 | 859 | 19 | 878 |
| South Dakota | 6 | 0.8 | 1 | 0.1 | 17 | — | 17 |
| Tennessee | 283 | 5.7 | 308 | 6.2 | 923 | 13 | 936 |
| Texas | 2,351 | 13.5 | 2,849 | 16.0 | 9,629 | 82 | 9,711 |
| Utah | 77 | 4.4 | 88 | 5.0 | 282 | 8 | 290 |
| Vermont | 14 | 2.5 | 19 | 3.4 | 62 | 1 | 63 |
| Virginia | 391 | 6.4 | 601 | 9.8 | 1,722 | 32 | 1,754 |
| Washington | 453 | 9.8 | 520 | 11.1 | 1,833 | 11 | 1,844 |
| West Virginia | 37 | 2.0 | 63 | 3.4 | 147 | 2 | 149 |
| Wisconsin | 113 | 2.3 | 176 | 3.6 | 528 | 3 | 531 |
| Wyoming | 15 | 3.0 | 5 | 1.0 | 32 | — | 32 |
| **U.S. total** | **32,078** | **12.9** | **38,502** | **15.4** | **133,400** | **2,244** | **135,644** |
| Guam | 1 | 0.7 | 1 | 0.7 | 7 | — | 7 |
| Pacific Islands, U.S. | 1 | 0.7 | 1 | 0.7 | 2 | — | 2 |
| Puerto Rico | 1,398 | 42.3 | 1,493 | 45.0 | 3,907 | 132 | 4,039 |
| Virgin Islands, U.S. | 34 | 29.5 | 9 | 7.7 | 69 | 4 | 73 |
| **Total** | **33,512** | **13.3** | **40,006** | **15.7** | **137,385** | **2,380** | **139,765** |

[1]During June 1990, 3,496 cases and 2,256 deaths among adults/adolescents and 65 cases and 27 deaths among children were reported to CDC.

## Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1988 through June 1989, July 1989 through June 1990; and cumulative totals, by area and age group, through June 1990

| Metropolitan area of residence | July 1988-June 1989 | | July 1989-June 1990 | | Cumulative totals | | |
|---|---|---|---|---|---|---|---|
| | No. | Rate | No. | Rate | Adults/ adolescents | Children <13 years old | Total |
| Akron, Ohio | 32 | 5.0 | 22 | 3.4 | 90 | – | 90 |
| Albany-Schenectady, N.Y. | 58 | 6.8 | 92 | 10.8 | 287 | 3 | 290 |
| Albuquerque, N.M. | 42 | 8.2 | 54 | 10.4 | 154 | 1 | 155 |
| Allentown, Pa. | 31 | 4.6 | 54 | 7.9 | 135 | 4 | 139 |
| Anaheim, Calif. | 264 | 11.5 | 332 | 14.2 | 1,151 | 8 | 1,159 |
| Atlanta, Ga. | 772 | 27.3 | 931 | 32.0 | 2,781 | 25 | 2,806 |
| Austin, Tex. | 151 | 19.1 | 224 | 27.3 | 601 | 5 | 606 |
| Bakersfield, Calif. | 17 | 3.2 | 44 | 8.1 | 98 | – | 98 |
| Baltimore, Md. | 397 | 16.9 | 580 | 24.6 | 1,524 | 46 | 1,570 |
| Baton Rouge, La. | 47 | 8.6 | 66 | 11.9 | 174 | 2 | 176 |
| Bergen-Passaic, N.J. | 243 | 18.7 | 280 | 21.6 | 1,166 | 25 | 1,191 |
| Birmingham, Ala. | 81 | 8.7 | 61 | 6.5 | 234 | 6 | 240 |
| Boston, Mass. | 613 | 16.3 | 613 | 16.3 | 2,278 | 48 | 2,326 |
| Bridgeport, Conn. | 135 | 16.5 | 115 | 14.0 | 485 | 17 | 502 |
| Buffalo, N.Y. | 42 | 4.5 | 99 | 10.6 | 227 | 2 | 229 |
| Charleston, S.C. | 56 | 10.7 | 83 | 15.6 | 204 | – | 204 |
| Charlotte, N.C. | 76 | 6.7 | 95 | 8.3 | 283 | 5 | 288 |
| Chicago, Ill. | 890 | 14.3 | 1,036 | 16.6 | 3,427 | 44 | 3,471 |
| Cincinnati, Ohio | 65 | 4.5 | 112 | 7.7 | 298 | 6 | 304 |
| Cleveland, Ohio | 137 | 7.4 | 117 | 6.4 | 499 | 7 | 506 |
| Columbus, Ohio | 128 | 9.5 | 122 | 9.0 | 431 | 3 | 434 |
| Dallas, Tex. | 546 | 21.0 | 635 | 23.7 | 2,349 | 11 | 2,360 |
| Dayton, Ohio | 61 | 6.5 | 54 | 5.7 | 192 | 3 | 195 |
| Denver, Colo. | 284 | 16.7 | 310 | 18.0 | 1,129 | 5 | 1,134 |
| Detroit, Mich. | 357 | 8.2 | 377 | 8.7 | 1,186 | 19 | 1,205 |
| El Paso, Tex. | 10 | 1.7 | 40 | 6.5 | 85 | 1 | 86 |
| Fort Lauderdale, Fla. | 473 | 39.4 | 883 | 72.5 | 2,175 | 42 | 2,217 |
| Fort Worth, Tex. | 139 | 10.2 | 167 | 11.9 | 527 | 7 | 534 |
| Fresno, Calif. | 51 | 8.3 | 56 | 8.9 | 165 | 2 | 167 |
| Gary, Ind. | 17 | 2.9 | 28 | 4.8 | 75 | – | 75 |
| Grand Rapids, Mich. | 31 | 4.6 | 19 | 2.8 | 77 | 1 | 78 |
| Greensboro, N.C. | 62 | 6.6 | 82 | 8.7 | 214 | 4 | 218 |
| Greenville, S.C. | 28 | 4.5 | 38 | 6.0 | 104 | – | 104 |
| Harrisburg, Pa. | 46 | 7.8 | 41 | 6.9 | 145 | 4 | 149 |
| Hartford, Conn. | 134 | 12.0 | 154 | 13.7 | 479 | 10 | 489 |
| Honolulu, Hawaii | 93 | 10.9 | 124 | 14.4 | 417 | 2 | 419 |
| Houston, Tex. | 852 | 25.7 | 1,149 | 34.0 | 4,106 | 31 | 4,137 |
| Indianapolis, Ind. | 117 | 9.4 | 137 | 10.9 | 399 | 3 | 402 |
| Jacksonville, Fla. | 149 | 16.2 | 242 | 25.7 | 592 | 12 | 604 |
| Jersey City, N.J. | 412 | 75.9 | 282 | 52.1 | 1,503 | 34 | 1,537 |
| Kansas City, Mo. | 204 | 12.9 | 322 | 20.1 | 862 | 3 | 865 |
| Knoxville, Tenn. | 28 | 4.7 | 28 | 4.6 | 98 | – | 98 |
| Lake County, Ill. | 16 | 3.1 | 18 | 3.5 | 64 | 2 | 66 |
| Las Vegas, Nev. | 98 | 15.4 | 132 | 20.2 | 380 | 5 | 385 |
| Little Rock, Ark. | 30 | 5.7 | 52 | 9.8 | 139 | 3 | 142 |
| Los Angeles, Calif. | 1,778 | 20.2 | 2,294 | 25.7 | 9,118 | 81 | 9,199 |
| Louisville, Ky. | 46 | 4.7 | 62 | 6.4 | 174 | 2 | 176 |
| Memphis, Tenn. | 78 | 7.9 | 109 | 10.9 | 305 | 5 | 310 |
| Miami, Fla. | 959 | 52.6 | 1,077 | 58.6 | 3,541 | 145 | 3,686 |
| Middlesex, N.J. | 198 | 19.9 | 173 | 17.1 | 709 | 22 | 731 |
| Milwaukee, Wis. | 68 | 4.9 | 96 | 6.9 | 308 | 1 | 309 |
| Minneapolis-Saint Paul, Minn. | 155 | 6.5 | 158 | 6.5 | 629 | 6 | 635 |
| Mobile, Ala. | 42 | 8.5 | 34 | 6.8 | 157 | – | 157 |
| Monmouth-Ocean City, N.J. | 165 | 16.6 | 170 | 16.8 | 543 | 20 | 563 |
| Nashville, Tenn. | 106 | 10.7 | 87 | 8.6 | 296 | 6 | 302 |
| Nassau-Suffolk, N.Y. | 329 | 12.5 | 413 | 15.7 | 1,438 | 37 | 1,475 |
| New Haven, Conn. | 116 | 14.5 | 130 | 16.2 | 519 | 26 | 545 |
| New Orleans, La. | 264 | 19.8 | 390 | 29.0 | 1,244 | 18 | 1,262 |

**Table 2. AIDS cases and annual rates per 100,000 population, by metropolitan area with 500,000 or more population, reported July 1988 through June 1989, July 1989 through June 1990; and cumulative totals, by area and age group, through June 1990 — Continued**

| Metropolitan area of residence | July 1988-June 1989 | | July 1989-June 1990 | | Cumulative totals | | |
|---|---|---|---|---|---|---|---|
| | No. | Rate | No. | Rate | Adults/ adolescents | Children <13 years old | Total |
| New York, N.Y. | 5,571 | 65.0 | 6,474 | 75.3 | 26,140 | 635 | 26,775 |
| Newark, N.J. | 1,012 | 53.3 | 964 | 50.7 | 3,782 | 103 | 3,885 |
| Norfolk, Va. | 86 | 6.2 | 153 | 10.8 | 382 | 7 | 389 |
| Oakland, Calif. | 319 | 15.8 | 507 | 24.8 | 1,676 | 10 | 1,686 |
| Oklahoma City, Okla. | 78 | 7.8 | 113 | 11.2 | 318 | — | 318 |
| Omaha, Neb. | 29 | 4.6 | 34 | 5.4 | 109 | 1 | 110 |
| Orlando, Fla. | 186 | 18.7 | 187 | 18.2 | 562 | 7 | 569 |
| Oxnard-Ventura, Calif. | 38 | 5.8 | 39 | 5.8 | 129 | — | 129 |
| Philadelphia, Pa. | 760 | 15.5 | 830 | 16.8 | 2,914 | 46 | 2,960 |
| Phoenix, Ariz. | 183 | 8.7 | 285 | 13.1 | 859 | 4 | 863 |
| Pittsburgh, Pa. | 135 | 6.5 | 143 | 7.0 | 492 | 2 | 494 |
| Portland, Oreg. | 157 | 13.2 | 213 | 17.8 | 664 | 2 | 666 |
| Providence, R.I. | 77 | 8.5 | 88 | 9.7 | 307 | 6 | 313 |
| Raleigh-Durham, N.C. | 73 | 10.4 | 123 | 17.2 | 308 | 8 | 316 |
| Richmond, Va. | 83 | 9.8 | 128 | 15.0 | 336 | 7 | 343 |
| Riverside-San Bernardino, Calif. | 216 | 9.4 | 260 | 11.0 | 866 | 14 | 880 |
| Rochester, N.Y. | 71 | 7.3 | 88 | 9.0 | 317 | 2 | 319 |
| Sacramento, Calif. | 174 | 12.4 | 122 | 8.5 | 552 | 5 | 557 |
| Saint Louis, Mo. | 182 | 7.3 | 210 | 8.4 | 658 | 6 | 664 |
| Salt Lake City, Utah | 64 | 5.8 | 76 | 6.8 | 248 | 5 | 253 |
| San Antonio, Tex. | 352 | 25.5 | 202 | 14.3 | 689 | 9 | 698 |
| San Diego, Calif. | 453 | 18.8 | 724 | 29.3 | 2,067 | 17 | 2,084 |
| San Francisco, Calif. | 1,813 | 112.5 | 1,938 | 119.3 | 8,440 | 17 | 8,457 |
| San Jose, Calif. | 158 | 11.0 | 139 | 9.6 | 609 | 7 | 616 |
| San Juan, P.R. | 886 | 56.7 | 938 | 59.8 | 2,420 | 89 | 2,509 |
| Scranton, Pa. | 23 | 3.1 | 34 | 4.6 | 100 | 3 | 103 |
| Seattle, Wash. | 341 | 18.4 | 395 | 21.1 | 1,405 | 9 | 1,414 |
| Springfield, Mass. | 40 | 6.8 | 67 | 11.4 | 155 | 7 | 162 |
| Syracuse, N.Y. | 18 | 2.8 | 54 | 8.4 | 139 | 4 | 143 |
| Tacoma, Wash. | 29 | 5.2 | 37 | 6.5 | 119 | 1 | 120 |
| Tampa, Fla. | 445 | 21.7 | 387 | 18.4 | 1,326 | 22 | 1,348 |
| Toledo, Ohio | 21 | 3.4 | 40 | 6.6 | 96 | 3 | 99 |
| Tucson, Ariz. | 55 | 8.4 | 57 | 8.6 | 214 | 2 | 216 |
| Tulsa, Okla. | 52 | 7.0 | 55 | 7.3 | 176 | 3 | 179 |
| Washington, D.C. | 864 | 22.9 | 973 | 25.4 | 3,841 | 54 | 3,895 |
| West Palm Beach, Fla. | 324 | 38.2 | 348 | 39.7 | 1,174 | 50 | 1,224 |
| Wilmington, Del. | 70 | 12.3 | 74 | 12.8 | 221 | 3 | 224 |
| Worcester, Mass. | 37 | 5.5 | 37 | 5.5 | 138 | 3 | 141 |
| **Metropolitan area subtotal[1]** | **28,294** | **19.3** | **33,231** | **22.5** | **117,918** | **2,003** | **119,921** |
| **All other areas** | **5,218** | **5.1** | **6,775** | **6.5** | **19,467** | **377** | **19,844** |
| **Total** | **33,512** | **13.3** | **40,006** | **15.7** | **137,385** | **2,380** | **139,765** |

[1] Includes data from metropolitan areas which have populations of 500,000 or more.

## Table 3. AIDS cases by age group, exposure category, and sex, reported July 1988 through June 1989, July 1989 through June 1990; and cumulative totals, by age group and exposure category, through June 1990, United States

| Adult/adolescent exposure category | Males | | Females | | Totals | | |
|---|---|---|---|---|---|---|---|
| | July 1988-June 1989 | July 1989-June 1990 | July 1988-June 1989 | July 1989-June 1990 | July 1988-June 1989 | July 1989-June 1990 | Cumulative total[1] |
| | No. (%) | No. (%) | No. (%) | No. (%) | No. (%) | No. (%) | No. (%) |
| Male homosexual/bisexual contact | 18,927 (64) | 22,103 (63) | – | – | 18,927 (58) | 22,103 (56) | 82,304 (60) |
| Intravenous (IV) drug use (female and heterosexual male) | 6,003 (20) | 7,116 (20) | 1,793 (52) | 2,111 (49) | 7,796 (24) | 9,227 (23) | 29,487 (21) |
| Male homosexual/bisexual contact and IV drug use | 2,121 ( 7) | 2,271 ( 6) | – | – | 2,121 ( 6) | 2,271 ( 6) | 9,370 ( 7) |
| Hemophilia/coagulation disorder | 310 ( 1) | 287 ( 1) | 7 ( 0) | 8 ( 0) | 317 ( 1) | 295 ( 1) | 1,234 ( 1) |
| Heterosexual contact: | 677 ( 2) | 921 ( 3) | 1,119 (32) | 1,417 (33) | 1,796 ( 5) | 2,338 ( 6) | 6,952 ( 5) |
| *Sex with IV drug user* | *335* | *410* | *723* | *895* | *1,058* | *1,305* | *3,627* |
| *Sex with bisexual male* | *–* | *–* | *86* | *115* | *86* | *115* | *415* |
| *Sex with person with hemophilia* | *2* | *2* | *10* | *26* | *12* | *28* | *68* |
| *Born in Pattern-II[2] country* | *232* | *313* | *126* | *138* | *358* | *451* | *1,861* |
| *Sex with person born in Pattern-II country* | *12* | *17* | *9* | *20* | *21* | *37* | *101* |
| *Sex with transfusion recipient with HIV infection* | *10* | *15* | *23* | *28* | *33* | *43* | *109* |
| *Sex with HIV-infected person, risk not specified* | *86* | *164* | *142* | *195* | *228* | *359* | *773* |
| Receipt of blood transfusion, blood components, or tissue[3] | 461 ( 2) | 494 ( 1) | 335 (10) | 340 ( 8) | 796 ( 2) | 834 ( 2) | 3,273 ( 2) |
| Other/undetermined[4] | 947 ( 3) | 1,834 ( 5) | 192 ( 6) | 407 (10) | 1,139 ( 3) | 2,241 ( 6) | 4,765 ( 3) |
| Adult/adolescent subtotal | 29,446 (100) | 35,026 (100) | 3,446 (100) | 4,283 (100) | 32,892 (100) | 39,309 (100) | 137,385 (100) |
| **Pediatric (<13 years old) exposure category** | | | | | | | |
| Hemophilia/coagulation disorder | 33 (10) | 26 ( 7) | 1 ( 0) | – | 34 ( 5) | 26 ( 4) | 119 ( 5) |
| Mother with/at risk for HIV infection: | 262 (77) | 294 (82) | 256 (92) | 307 (90) | 518 (84) | 601 (86) | 1,966 (83) |
| *IV drug use* | *137* | *139* | *114* | *138* | *251* | *277* | *991* |
| *Sex with IV drug user* | *52* | *75* | *56* | *70* | *108* | *145* | *415* |
| *Sex with bisexual male* | *5* | *6* | *4* | *9* | *9* | *15* | *46* |
| *Sex with person with hemophilia* | *–* | *–* | *1* | *1* | *1* | *1* | *8* |
| *Born in Pattern-II country* | *28* | *24* | *26* | *22* | *54* | *46* | *197* |
| *Sex with person born in Pattern-II country* | *1* | *2* | *2* | *2* | *3* | *4* | *10* |
| *Sex with transfusion recipient with HIV infection* | *3* | *–* | *4* | *2* | *7* | *2* | *10* |
| *Sex with HIV-infected person, risk not specified* | *11* | *13* | *13* | *18* | *24* | *31* | *83* |
| *Receipt of blood transfusion, blood components, or tissue* | *3* | *6* | *9* | *4* | *12* | *10* | *40* |
| *Has HIV infection, risk not specified* | *22* | *29* | *27* | *41* | *49* | *70* | *166* |
| Receipt of blood transfusion, blood components, or tissue | 38 (11) | 23 ( 6) | 16 ( 6) | 15 ( 4) | 54 ( 9) | 38 ( 5) | 233 (10) |
| Undetermined | 8 ( 2) | 14 ( 4) | 6 ( 2) | 18 ( 5) | 14 ( 2) | 32 ( 5) | 62 ( 3) |
| Pediatric subtotal | 341 (100) | 357 (100) | 279 (100) | 340 (100) | 620 (100) | 697 (100) | 2,380 (100) |
| **Total** | **29,787** | **35,383** | **3,725** | **4,623** | **33,512** | **40,006** | **139,765** |

[1] Includes 3 patients known to be infected with human immunodeficiency virus type 2 (HIV-2). See MMWR 1989;38:572-580

[2] See technical notes.

[3] Includes 12 transfusion recipients who received blood screened for HIV antibody, and 1 tissue recipient.

[4] "Other" refers to 3 health-care workers who seroconverted to HIV and developed AIDS after occupational exposure to HIV-infected blood. "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.

## Table 4. AIDS cases by age group, exposure category, and race/ethnicity, reported through June 1990, United States

| Adult/adolescent exposure category | White, not Hispanic No. (%) | Black, not Hispanic No. (%) | Hispanic No. (%) | Asian/Pacific Islander No. (%) | American Indian/ Alaskan Native No. (%) | Total[4] No. (%) |
|---|---|---|---|---|---|---|
| Male homosexual/bisexual contact | 59,000 (77) | 13,717 (36) | 8,673 (41) | 633 (75) | 101 (53) | 82,304 (60) |
| Intravenous (IV) drug use (female and heterosexual male) | 5,964 ( 8) | 14,777 (39) | 8,598 (40) | 35 ( 4) | 33 (17) | 29,487 (21) |
| Male homosexual/bisexual contact and IV drug use | 5,494 ( 7) | 2,475 ( 7) | 1,347 ( 6) | 16 ( 2) | 24 (13) | 9,370 ( 7) |
| Hemophilia/coagulation disorder | 1,032 ( 1) | 82 ( 0) | 93 ( 0) | 15 ( 2) | 8 ( 4) | 1,234 ( 1) |
| Heterosexual contact: | 1,445 ( 2) | 4,273 (11) | 1,177 ( 6) | 31 ( 4) | 8 ( 4) | 6,952 ( 5) |
| *Sex with IV drug user* | *802* | *1,857* | *941* | *13* | *5* | *3,627* |
| *Sex with bisexual male* | *225* | *132* | *50* | *6* | *1* | *415* |
| *Sex with person with hemophilia* | *57* | *7* | *1* | *1* | — | *66* |
| *Born in Pattern-II[1] country* | *5* | *1,836* | *11* | *4* | — | *1,861* |
| *Sex with person born in Pattern-II country* | *33* | *62* | *5* | — | — | *101* |
| *Sex with transfusion recipient with HIV infection* | *76* | *18* | *12* | *1* | — | *109* |
| *Sex with HIV-infected person, risk not specified* | *247* | *361* | *157* | *6* | *2* | *773* |
| Receipt of blood transfusion, blood components, or tissue[2] | 2,335 ( 3) | 549 ( 1) | 314 ( 1) | 66 ( 8) | 3 ( 2) | 3,273 ( 2) |
| Other/undetermined[3] | 1,815 ( 2) | 1,809 ( 5) | 1,035 ( 5) | 52 ( 6) | 12 ( 6) | 4,765 ( 3) |
| Adult/adolescent subtotal | 77,085(100) | 37,682 (100) | 21,237(100) | 848(100) | 189(100) | 137,385(100) |
| **Pediatric (<13 years old) exposure category** | | | | | | |
| Hemophilia/coagulation disorder | 83 (16) | 16 ( 1) | 16 ( 3) | 3 (25) | — | 119 ( 5) |
| Mother with/at risk for HIV infection: | 303 (58) | 1,128 (92) | 521 (86) | 4 (33) | 5(100) | 1,966 (83) |
| *IV drug use* | *148* | *563* | *275* | *1* | *2* | *991* |
| *Sex with IV drug user* | *67* | *180* | *166* | *1* | — | *415* |
| *Sex with bisexual male* | *17* | *20* | *9* | — | — | *46* |
| *Sex with person with hemophilia* | *5* | *2* | *1* | — | — | *8* |
| *Born in Pattern-II country* | *2* | *194* | *1* | — | — | *197* |
| *Sex with person born in Pattern-II country* | — | *9* | — | — | — | *10* |
| *Sex with transfusion recipient with HIV infection* | *5* | *3* | *2* | — | — | *10* |
| *Sex with HIV-infected person, risk not specified* | *14* | *37* | *29* | *1* | *1* | *83* |
| *Receipt of blood transfusion, blood components, or tissue* | *14* | *15* | *11* | — | — | *40* |
| *Has HIV infection, risk not specified* | *31* | *105* | *27* | *1* | *2* | *166* |
| Receipt of blood transfusion, blood components, or tissue | 126 (24) | 51 ( 4) | 51 ( 8) | 5 (42) | — | 233 (10) |
| Undetermined | 9 ( 2) | 32 ( 3) | 21 ( 3) | — | — | 62 ( 3) |
| Pediatric subtotal | 521(100) | 1,227 (100) | 609(100) | 12(100) | 5(100) | 2,380(100) |
| **Total** | **77,606** | **38,909** | **21,846** | **860** | **194** | **139,765** |

[1] See technical notes.

[2] Includes 12 transfusion recipients who received blood screened for HIV antibody, and 1 tissue recipient.

[3] "Other" refers to 3 health-care workers who seroconverted to HIV and developed AIDS after occupational exposure to HIV-infected blood. "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.

[4] Includes 350 persons whose race/ethnicity is unknown.

## Table 5. Adult/adolescent AIDS cases by sex, exposure category, and race/ethnicity, reported through June 1990, United States

| Male exposure category | White, not Hispanic No. (%) | Black, not Hispanic No. (%) | Hispanic No. (%) | Asian/Pacific Islander No. (%) | American Indian/ Alaskan Native No. (%) | Total[4] No. (%) |
|---|---|---|---|---|---|---|
| Male homosexual/bisexual contact | 59,000 (80) | 13,717 (44) | 8,673 (46) | 633 (81) | 101 (62) | 82,304 (66) |
| Intravenous (IV) drug use (heterosexual) | 4,551 ( 6) | 10,889 (35) | 7,250 (39) | 23 ( 3) | 18 (11) | 22,798 (18) |
| Male homosexual/bisexual contact and IV drug use | 5,494 ( 7) | 2,475 ( 8) | 1,347 ( 7) | 16 ( 2) | 24 (15) | 9,370 ( 8) |
| Hemophilia/coagulation disorder | 1,008 ( 1) | 76 ( 0) | 92 ( 0) | 15 ( 2) | 8 ( 5) | 1,203 ( 1) |
| Heterosexual contact: | 459 ( 1) | 2,117 ( 7) | 237 ( 1) | 6 ( 1) | 1 ( 1) | 2,824 ( 2) |
| *Sex with IV drug user* | *292* | *589* | *155* | *2* | *1* | *1,039* |
| *Sex with person with hemophilia* | *4* | *1* | — | — | — | *5* |
| *Born in Pattern-II[1] country* | *3* | *1,342* | *8* | *3* | — | *1,359* |
| *Sex with person born in Pattern-II country* | *29* | *25* | *4* | — | — | *58* |
| *Sex with transfusion recipient with HIV infection* | *21* | *9* | *1* | — | — | *32* |
| *Sex with HIV-infected person, risk not specified* | *110* | *151* | *69* | *1* | — | *331* |
| Receipt of blood transfusion, blood components, or tissue[2] | 1,504 ( 2) | 295 ( 1) | 163 ( 1) | 42 ( 5) | 1 ( 1) | 2,010 ( 2) |
| Other/undetermined[3] | 1,573 ( 2) | 1,325 ( 4) | 890 ( 5) | 43 ( 6) | 9 ( 6) | 3,876 ( 3) |
| Male subtotal | 73,589 (100) | 30,894 (100) | 18,652 (100) | 778 (100) | 162 (100) | 124,385 (100) |
| **Female exposure category** | | | | | | |
| IV drug use | 1,413 (40) | 3,888 (57) | 1,348 (52) | 12 (17) | 15 (56) | 6,689 (51) |
| Hemophilia/coagulation disorder | 24 ( 1) | 6 ( 0) | 1 ( 0) | — | — | 31 ( 0) |
| Heterosexual contact: | 986 (28) | 2,156 (32) | 940 (36) | 25 (36) | 7 (26) | 4,128 (32) |
| *Sex with IV drug user* | *510* | *1,268* | *786* | *11* | *4* | *2,588* |
| *Sex with bisexual male* | *225* | *132* | *50* | *6* | *1* | *415* |
| *Sex with person with hemophilia* | *53* | *6* | *1* | *1* | — | *61* |
| *Born in Pattern-II country* | *2* | *494* | *3* | *1* | — | *502* |
| *Sex with person born in Pattern-II country* | *4* | *37* | *1* | — | — | *43* |
| *Sex with transfusion recipient with HIV infection* | *55* | *9* | *11* | *1* | — | *77* |
| *Sex with HIV-infected person, risk not specified* | *137* | *210* | *88* | *5* | *2* | *442* |
| Receipt of blood transfusion, blood components, or tissue | 831 (24) | 254 ( 4) | 151 ( 6) | 24 (34) | 2 ( 7) | 1,263 (10) |
| Other/undetermined | 242 ( 7) | 484 ( 7) | 145 ( 6) | 9 (13) | 3 (11) | 889 ( 7) |
| Female subtotal | 3,496 (100) | 6,788 (100) | 2,585 (100) | 70 (100) | 27 (100) | 13,000 (100) |
| **Total** | **77,085** | **37,682** | **21,237** | **848** | **189** | **137,385** |

[1] See technical notes.
[2] Includes 12 transfusion recipients who received blood screened for HIV antibody, and 1 tissue recipient.
[3] "Other" refers to 3 health-care workers who seroconverted to HIV and developed AIDS after occupational exposure to HIV-infected blood. "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.
[4] Includes 310 males and 34 females whose race/ethnicity is unknown.

## Table 6. AIDS cases in adolescents and adults under age 25, by exposure category, reported July 1988 through June 1989, July 1989 through June 1990, and cumulative totals through June 1990, United States

| Exposure category | 13-19 years old | | | | | | 20-24 years old | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | July1988-June 1989 | | July 1989-June 1990 | | Cumulative total | | July 1988-June 1989 | | July 1989-June 1990 | | Cumulative total | |
| | No. | (%) | No. | (%) | No. | (%) | No. | (%) | No. | (%) | No. | (%) |
| Male homosexual/bisexual contact | 35 | (30) | 35 | (24) | 152 | (28) | 812 | (58) | 806 | (51) | 3,393 | (57) |
| Intravenous (IV) drug use (female and heterosexual male) | 16 | (14) | 14 | ( 9) | 61 | (11) | 231 | (16) | 301 | (19) | 957 | (16) |
| Male homosexual/bisexual contact and IV drug use | 3 | ( 3) | 4 | ( 3) | 24 | ( 4) | 116 | ( 8) | 137 | ( 9) | 560 | ( 9) |
| Hemophilia/coagulation disorder | 34 | (29) | 44 | (30) | 167 | (31) | 40 | ( 3) | 32 | ( 2) | 151 | ( 3) |
| Heterosexual contact: | 15 | (13) | 26 | (18) | 65 | (12) | 137 | (10) | 183 | (12) | 539 | ( 9) |
| *Sex with IV drug user* | *9* | | *16* | | *38* | | *84* | | *106* | | *297* | |
| *Sex with bisexual male* | — | | *1* | | *3* | | *11* | | *6* | | *44* | |
| *Sex with person with hemophilia* | — | | *1* | | *1* | | *4* | | *6* | | *14* | |
| *Born in Pattern-II[1] country* | *3* | | *2* | | *13* | | *14* | | *27* | | *104* | |
| *Sex with person born in Pattern-II country* | — | | — | | — | | *1* | | *3* | | *6* | |
| *Sex with transfusion recipient with HIV infection* | — | | — | | — | | — | | *5* | | *6* | |
| *Sex with HIV-infected person, risk not specified* | *3* | | *6* | | *10* | | *23* | | *30* | | *68* | |
| Receipt of blood transfusion, blood components, or tissue | 12 | (10) | 7 | ( 5) | 42 | ( 8) | 21 | ( 1) | 15 | ( 1) | 88 | ( 1) |
| Undetermined[2] | 2 | ( 2) | 18 | (12) | 30 | ( 6) | 54 | ( 4) | 108 | ( 7) | 244 | ( 4) |
| **Total** | **117** | **(100)** | **148** | **(100)** | **541** | **(100)** | **1,411** | **(100)** | **1,582** | **(100)** | **5,932** | **(100)** |

[1] See technical notes.
[2] "Undetermined" refers to patients whose mode of exposure to HIV is unknown. This includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation. See Figure 4.

## Table 7. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through June 1990, United States

| Males<br>Age at diagnosis (years) | White, not Hispanic<br>No. (%) | Black, not Hispanic<br>No. (%) | Hispanic<br>No. (%) | Asian/Pacific Islander<br>No. (%) | American Indian/ Alaskan Native<br>No. (%) | Total[1]<br>No. (%) |
|---|---|---|---|---|---|---|
| Under 5 | 180 ( 0) | 553 ( 2) | 272 ( 1) | 3 ( 0) | 2 ( 1) | 1,013 ( 1) |
| 5-12 | 140 ( 0) | 75 ( 0) | 49 ( 0) | 5 ( 1) | — | 271 ( 0) |
| 13-19 | 208 ( 0) | 127 ( 0) | 77 ( 0) | 5 ( 1) | 4 ( 2) | 422 ( 0) |
| 20-24 | 2,606 ( 4) | 1,479 ( 5) | 891 ( 5) | 27 ( 3) | 10 ( 6) | 5,024 ( 4) |
| 25-29 | 11,204 (15) | 5,046 (16) | 3,250 (17) | 105 (13) | 34 (21) | 19,675 (16) |
| 30-34 | 17,398 (24) | 7,945 (25) | 4,881 (26) | 170 (22) | 43 (26) | 30,506 (24) |
| 35-39 | 16,142 (22) | 7,224 (23) | 4,143 (22) | 168 (21) | 27 (16) | 27,784 (22) |
| 40-44 | 10,987 (15) | 4,138 (13) | 2,566 (14) | 125 (16) | 19 (12) | 17,884 (14) |
| 45-49 | 6,536 ( 9) | 2,261 ( 7) | 1,309 ( 7) | 81 (10) | 14 ( 9) | 10,226 ( 8) |
| 50-54 | 3,700 ( 5) | 1,259 ( 4) | 752 ( 4) | 41 ( 5) | 3 ( 2) | 5,770 ( 5) |
| 55-59 | 2,345 ( 3) | 777 ( 2) | 463 ( 2) | 26 ( 3) | 5 ( 3) | 3,630 ( 3) |
| 60-64 | 1,287 ( 2) | 402 ( 1) | 194 ( 1) | 7 ( 1) | 3 ( 2) | 1,899 ( 2) |
| 65 or older | 1,176 ( 2) | 236 ( 1) | 126 ( 1) | 23 ( 3) | — | 1,565 ( 1) |
| Male subtotal | 73,909 (100) | 31,522 (100) | 18,973 (100) | 786 (100) | 164 (100) | 125,669 (100) |
| **Females** | | | | | | |
| **Age at diagnosis (years)** | | | | | | |
| Under 5 | 168 ( 5) | 528 ( 7) | 248 ( 9) | 1 ( 1) | 3 (10) | 949 ( 7) |
| 5-12 | 33 ( 1) | 71 ( 1) | 40 ( 1) | 3 ( 4) | — | 147 ( 1) |
| 13-19 | 32 ( 1) | 66 ( 1) | 19 ( 1) | 1 ( 1) | 1 ( 3) | 119 ( 1) |
| 20-24 | 246 ( 7) | 433 ( 6) | 219 ( 8) | 3 ( 4) | 3 (10) | 908 ( 6) |
| 25-29 | 670 (18) | 1,329 (18) | 611 (21) | 8 (11) | 3 (10) | 2,629 (19) |
| 30-34 | 797 (22) | 2,028 (27) | 711 (25) | 15 (20) | 10 (33) | 3,570 (25) |
| 35-39 | 545 (15) | 1,507 (20) | 507 (18) | 7 ( 9) | 5 (17) | 2,577 (18) |
| 40-44 | 293 ( 8) | 690 ( 9) | 260 ( 9) | 13 (18) | 2 ( 7) | 1,259 ( 9) |
| 45-49 | 160 ( 4) | 291 ( 4) | 113 ( 4) | 7 ( 9) | — | 575 ( 4) |
| 50-54 | 126 ( 3) | 178 ( 2) | 55 ( 2) | 5 ( 7) | 1 ( 3) | 365 ( 3) |
| 55-59 | 141 ( 4) | 112 ( 2) | 40 ( 1) | 3 ( 4) | — | 298 ( 2) |
| 60-64 | 134 ( 4) | 70 ( 1) | 23 ( 1) | 5 ( 7) | 1 ( 3) | 233 ( 2) |
| 65 or older | 352 (10) | 84 ( 1) | 27 ( 1) | 3 ( 4) | 1 ( 3) | 467 ( 3) |
| Female subtotal | 3,697 (100) | 7,387 (100) | 2,873 (100) | 74 (100) | 30 (100) | 14,096 (100) |
| **Total** | **77,606** | **38,909** | **21,846** | **860** | **194** | **139,765** |

[1] Includes 350 persons whose race/ethnicity is unknown.

## Table 10. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through June 1990, United States

| Exposure category | AIDS cases | |
|---|---|---|
| | No. | ( %) |
| **Single mode of exposure** | | |
| Male homosexual/bisexual contact | 79,013 | (58) |
| Intravenous (IV) drug use (female and heterosexual male) | 25,298 | (18) |
| Hemophilia/coagulation disorder | 742 | ( 1) |
| Heterosexual contact | 6,623 | ( 5) |
| Receipt of transfusion of blood, blood component, or tissue | 3,273 | ( 2) |
| Other/undetermined | 4,765 | ( 3) |
| **Single mode of exposure subtotal** | 119,714 | (87) |
| **Multiple modes of exposure** | | |
| Male homosexual/bisexual contact; IV drug use | 8,452 | ( 6) |
| Male homosexual/bisexual contact; hemophilia | 32 | ( 0) |
| Male homosexual/bisexual contact; heterosexual contact | 1,641 | ( 1) |
| Male homosexual/bisexual contact; receipt of transfusion | 1,513 | ( 1) |
| IV drug use; hemophilia | 32 | ( 0) |
| IV drug use; heterosexual contact | 3,297 | ( 2) |
| IV drug use; receipt of transfusion | 652 | ( 0) |
| Hemophilia; heterosexual contact | 7 | ( 0) |
| Hemophilia; receipt of transfusion | 474 | ( 0) |
| Heterosexual contact; receipt of transfusion | 329 | ( 0) |
| Male homosexual/bisexual contact; IV drug use; hemophilia | 7 | ( 0) |
| Male homosexual/bisexual contact; IV drug use; heterosexual contact | 624 | ( 0) |
| Male homosexual/bisexual contact; IV drug use; receipt of transfusion | 247 | ( 0) |
| Male homosexual/bisexual contact; hemophilia; heterosexual contact | 3 | ( 0) |
| Male homosexual/bisexual contact; hemophilia; receipt of transfusion | 16 | ( 0) |
| Male homosexual/bisexual contact; heterosexual contact; receipt of transfusion | 86 | ( 0) |
| IV drug use; hemophilia; heterosexual contact | 3 | ( 0) |
| IV drug use; hemophilia; receipt of transfusion | 15 | ( 0) |
| IV drug use; heterosexual contact; receipt of transfusion | 187 | ( 0) |
| Hemophilia; heterosexual contact; receipt of transfusion | 11 | ( 0) |
| Male homosexual/bisexual contact; IV drug use; hemophilia; receipt of transfusion | 7 | ( 0) |
| Male homosexual/bisexual contact; IV drug use; heterosexual contact; receipt of transfusion | 33 | ( 0) |
| IV drug use; hemophilia; heterosexual contact; receipt of transfusion | 3 | ( 0) |
| **Multiple modes of exposure subtotal** | 17,671 | (13) |
| **Total** | 137,385 | (100) |

## APPENDIX B
## LIST OF RESOURCES AND CONTACTS FOR PUBLIC SAFETY PERSONNEL & AIDS INFORMATION

Some of the organizations listed below supply free information and some have current publications on AIDS and public safety policies.

1) **International Association of Fire Fighters**
1750 New York N.W. 3rd Floor
Washington, D.C. 20006
202-737-8484

2) **International Union of Police Association**
1016 Duke Street
Alexandria, Virginia 22314
703-549-7473

3) **The New York Business Group on Health, Inc.**
622 3rd Avenue 34th Floor
New York, New York 10017

4) **National Aids Information Clearinghouse**
P.O. Box 6003
Rockville, Maryland 20850
1-800-458-5231

5) **Department of Health and Human Services**
Public Health Service
Centers For Disease Control
Atlanta, Georgia 30333

6) **City of Philadelphia**
Department of Public Health
Aids Activities Coordinating Office
1220 Sansom Street
Philadelphia, PA 19107
215-686-1835

7) **United States Conference of Local Health Officers**
1620 Eye Street, Northwest
Washington, D.C. 20006
202-293-7330

8) **United States Conference of Mayors**
1620 Eye Street, Northwest
Washington, D.C. 20006
202-293-7330

9) **Fire Fighters Center for Infectious Disease Control**
4733 Bethesda Avenue
Suite 750
Bethesda, Maryland 20814
301-656-0003

10) **California Fire Fighters Foundation**
1780 Creekside Oaks
Suite 200
Sacramento, California 95833
916-921-9111

11) **American Red Cross**
P.O. Box 160167
Sacramento, California 95816
916-368-3131

12) **U.S. Surgeon General's Report on Aids**
P.O. Box 14252
Washington, D.C. 20044
202-245-6867

13) **San Francisco Aids Foundation**
333 Valencia Street 4th Floor
San Francisco, California 94103
415-861-3397

14) **Center for Health Promotion, George Mason University**
4400 University Drive
Fairfax, Virginia 22030
703-323-2827

## APPENDIX C
## REGIONAL AIDS COORDINATORS

The regional aids coordinates act as a liaison to state AIDS officials. They also are the regional contact for AIDS issues.

**Region 1 (CONNECTICUT, MAINE, MASSACHUSETTS, NEW HAMPSHIRE, RHODE ISLAND, VERMONT)**
Joy Koenig, M.D., M. Sc.
Associate Regional Health Administrator
for Clinical Service
U.S. Public Health Service
John F Kennedy Building
Boston, Mass. 02203
617-565-1420

**Region 2 (NEW JERSEY, NEW YORK, PUERTO RICO, VIRGIN ISLANDS)**
Barry Gordon, R. Ph.
Regional Aids Coordinator
U.S. Public Health Service
Federal Building
26 Federal Plaza, Room 3337
New York, New York 10278
212-264-2535

**Region 3 (DELAWARE, DISTRICT OF COLUMBIA, MARYLAND, VIRGINIA, PENNSYLVANIA, WEST VIRGINIA)**
Melvin Lerner, DDS
(Acting) Regional Aids Coordinator
U.S. Public Health Service
P.O. Box 13716
Philadelphia, Pennsylvania 19101
215-596-4526

**Region 4 (ALABAMA, FLORIDA, GEORGIA, KENTUCKY, MISSISSIPPI, NORTH CAROLINA, SOUTH CAROLINA, TENNESSEE)**
Beaumont R. Hagebak, M.D.
Associate Regional Health Administrator
and Aids Coordinator
U.S. Public Health Service
101 Marietta Tower, Suite 1104
Atlanta, Georgia 30323
404-331-6602

**Region 5 (ILLINOIS, INDIANA, MICHIGAN, MINNESOTA, OHIO, WISCONSIN)**
John N. Krzemien, Ph.D.
Regional Aids Coordinator
U.S. Public Health Service
105 West Adams Street 17th Floor
Chicago, Illinois 60603
312-353-1385

**Region 6 (ARKANSAS, LOUISIANA, NEW MEXICO, OKLAHOMA, TEXAS)**
Ted Karpf
Regional Aids Coordinator
U.S. Public Health Service
1200 Main Tower Building
Rm. 2360
Dallas, Texas 75202
214-729-0404

**Region 7 (IOWA, KANSAS, MISSOURI, NEBRASKA)**
William Mayfield
Regional Aids Coordinator
U.S. Public Health Service
601 East 12 th Street, Rm 501
Kansas City, Missouri 64106
816-867-2178

**Region 8 (COLORADO, MONTANA, NORTH DAKOTA, SOUTH DAKOTA, UTAH, WYOMING)**
Hugh Sloan
(Acting) Regional Aids Coordinator
U.S. Public Health Service
1185 Federal Building
1961 Stout Street
Denver, Colorado 80294
303-844-6163

**Region 9 (AMERICAN SAMOA, ARIZONA, CALIFORNIA, COMMONWEALTH OF THE NORTHERN MARIANAS ISLANDS, FEDERATED STATES OF MICRONESIA, GUAM, HAWAII, NEVADA, REPUBLIC OF THE MARSHALL ISLANDS, REPUBLIC OF PALAU)**
Alan Harris
Regional Aids Coordinator
U.S. Public Health Service
50 United Nations Plaza
San Fransico, California 94102
415-556-7371

**Region 10 (ALASKA, IDAHO, OREGON, WASHINGTON)**
Jay Paulsen, M.D.
Regional Aids Coordinator
U.S. Public Health Service
2201 Sixth Street, M.S. RX-20
Seattle, Washington 98121
206-442-0430

## APPENDIX D
## BASIC PRINCIPLES IN FORMULATING POLICY

Several critical principles are useful to consider when developing AIDS policies and laws. These principles differ little from those followed when approaching a high priority policy issue.

### Basic Principles For AIDS Policies and Laws

**Principle 1: AIDS policies and laws should be based on scientific and clinical facts.**

For example:

Fact: HIV is transmitted through direct infusion or significant exposure to blood or semen.

Public Policy: In most public situations, including work and school, an HIV infected individual poses no direct threat to others.

**Principle 2: AIDS policies and laws should balance the needs of individuals who are HIV infected with those of the general public.**

Individuals are guaranteed certain constitutional rights. State powers include protecting public health and safety. Both principles must be considered when developing appropriate AIDS policies.

**Principle 3: AIDS policies and laws should lead to logical, practical and sound public health consequences.**

For example, routinely using isolation and quarantine provisions may be impossible with AIDS. Unlike other diseases, AIDS has no cure, has no limited period of infection and is behavior based. Solutions must consider disease characteristics and the need to encourage behavioral change while housing and caring for individuals who are infected.

**Principle 4: AIDS policies and laws should be flexible to respond to change.**

As knowledge about AIDS continues to grow, medical standards and technical procedures may also need to change. Agencies may need the authority or policy foundation to react quickly to a changing AIDS technology.

**Principle 5: AIDS policies and laws should include consensus building and a rational decisionmaking process.**

AIDS is an emotional issue. Whenever possible, community provider and advocacy groups, among others, should be involved in discussion and planning efforts.

**Principle 6: AIDS policies and laws should build upon existing community resources.**

In an era of budget deficits and competing social needs, it is important to build upon existing creatively.

**Principle 7: AIDS policies and laws should be sensitive to the needs of special populations, including women, children, minorities, IV drug users, gay men and the indigent.**

Increasingly, AIDS is affecting minority populations, including women and children. It is also moving rapidly among IV drug users. These are the group most likely to have unmet needs or to require assistance.

**Principle 8: AIDS policies and laws should reflect the similarities that AIDS has with other diseases, while addressing its differences.**

AIDS is both a chronic and a terminal illness that will significantly affect public resources. This means that it must be approached like similar public health issues. At the same time, people with HIV infection suffer from discrimination and stigma. Until this changes, measures need to be adopted that protect the rights of HIV patients as people with debilitating conditions. This also promotes understanding and makes it easier to manage HIV infection like chronic conditions.

(These guidelines were taken from the George Washington University Intergovernmental Health Policy entitled, A Policymaker's Guide on AIDS, 1989, written by Mona Rowe and Caitlin Ryan.)

NATIONAL LEAGUE OF CITIES
CURRENT POLICY ON AIDS
ADOPTED AT THE ANNUAL
BUSINESS MEETING ON
NOVEMBER 29, 1989

*6. Acquired Immune Deficiency Syndrome (AIDS)*

As the nation's number one public health problem for the foreseeable future, Acquired Immune Deficiency Syndrome (AIDS) requires public policy actions of broad proportions. Projections of nearly 200,000 deaths from AIDS by 1991 suggest the preeminent need for research efforts to find both a cure and a preventive vaccine. In addition to its toll in human lives, AIDS exacts tremendous costs in health care, insurance premiums and loss of human productivity. The specter of AIDS also raises problems of discrimination in various forms, anxieties over public safety and misinformation about the causes of the disease and its potential for transmission.

In response to problems related to AIDS, it is incumbent upon all levels of government to play key public policy roles. Appropriate roles for each level of government are as follows:

a. The Federal government must lead the way to finding effective, affordable treatment and vaccines for AIDS through (1) its provision of resources for clinical and other types of research and (2) its direct involvement in such research efforts. All barriers to international collaboration in AIDS research must be eliminated; and

b. Until such time as the disease is eliminated, the Federal government must take the lead role in educating and informing the nation as to the magnitude of the AIDS epidemic and ways to prevent, or minimize, the risk for contracting the disease. To accomplish this effort, the Federal government must finance and/or produce: public service announcements for television and radio, newspaper and magazine advertisements, billboards, posters, leaflets and other packages of accurate practical information. Technical and financial assistance to state and local governments, community organizations and groups serving high-risk populations should be provided and Federal spokespersons should make frequent appearances to address the public's concerns.

c. Through the Civil Rights Division of the Justice Department and other agencies, the Federal government must: (1) ensure the protection of civil rights entitled to all individuals afflicted with AIDS, exposed to the AIDS virus, or perceived to be at-risk of contracting the disease; (2) include said anti-discriminatory language, the following: persons who have or are perceived to have AIDS, Human Immunodeficiency Virus (HIV), or AIDS Related Complex (ARC), including those who test positive for HIV antibodies but show no symptoms; and (3) aggressively enforce laws designed to prevent discrimination against such individuals.

d. With respect to testing individuals for the presence of the AIDS virus, such testing should occur strictly on a voluntary basis. The Federal government should encourage voluntary testing for AIDS by underwriting the costs of such testing and by encouraging individuals to be tested through public service messages and educational materials. In all cases, the results of AIDS testing should be maintained in strict confidentiality, and in cases where testing reveals a positive presence of the AIDS antibody, such information should not be permitted to deny individuals eligibility for life and health insurance or access to health care services. We urge Congress to pass legislation necessary to ensure such protections.

e. State governments, primarily through state health agencies and departments of education, should develop and implement programs of education and information concerning AIDS. Such programs should be complementary to and coordinated with federal efforts and should be oriented for use at the local level. States should play a leading role in educating medical and allied health professionals on prevention, diagnosis and treatment of the disease. States should provide funding and technical assistance to local governments and community groups for community initiatives to combat AIDS. States should also develop anti-discrimination laws to protect persons who have or are perceived to have AIDS, ARC, or HIV, including those who test positive for HIV antibodies but show no symptoms.

f. Local elected officials should exercise community leadership in elevating AIDS as a top health priority. The formation of local task forces which bring together health officials, human service providers, school administrators and teachers, public safety personnel, community group leaders, clergy and other relevant actors should be considered. Through these coalitions, city ordinances should be developed that protect those persons who have or are perceived to have AIDS, ARC, or HIV, including those who test positive for HIV antibodies but show no symptoms. Areas of protection should include (but not be limited to): housing, employment, public accommodations and education. The local business community should assist financially and through participation in local task forces. Funding and other resources should also be sought from state and federal agencies, as well as from philanthropic organizations.

g. Local AIDS-related programs should aim to educate and sensitize the entire population about the present and future potential of the disease. Further, local programs should identify high-risk segments of the population and target information,

health services and other services to these populations. Special educational efforts both in and out of school, should be tailored to teenagers, young adults and parents. For persons afflicted with AIDS, essential services such as medical and hospital care, counseling, employment assistance and housing assistance should be provided. Where necessary, housing alternatives such as hospice care, should be available. Counseling services should be made available to families and friends of AIDS victims as well.

h. Local governments should develop specific educational and training programs for the general public, local officials and city employees as to the causes of AIDS, behaviors which result in transmission, and appropriate prevention strategies. Broader municipal government programs should include awareness and prevention strategies, as well as nondiscrimination policies and workplace policies governing employees with AIDS, ARC, HIV, including those who test positive for HIV anti-bodies but show no symptoms. Local governments should strive to establish AIDS-related policies and programs which can serve as models for businesses and non-profit organizations in the community as well. Local governments should also work with school systems to prevent discrimination against children with AIDS and to ensure that such childrens' education are continued despite their illness.

In conclusion, unless the Federal government plays a major financial role in the national public health emergency of AIDS, the state and local government's hands are tied. Specific financial support should come from Washington in the following areas:

i. appropriate funds provided through the Office of Minority Health for local jurisdictions where funds are most needed;

j. increased financial responsibility for the care provided to persons with AIDS by waiving the 24-month Medicare waiting period for this population and, by subsidizing hospitals that provide charity care;

k. adequate funding to assure the most widespread availability of, and access to, voluntary, confidential HIV antibody testing, which includes pre-post test counseling, informed consent and referrals for appropriate health care and psychosocial services;

l. renewed federal financial commitment to provide life prolonging drugs, to medically indigent individuals for whom these drugs are not covered under Medicaid or third party payers;

m. increased funding for chemical dependent treatment and changes in regulations governing methadone maintenance, to make available access to all addicts in need of care and appropriate support services for their families;

n. adequate funding for AIDS prevention education and development, in consultation with local officials, of an educational strategy for the general public with a targeted emphasis on the high risk groups;

o. a new funding strategy to relieve the disproportionate financial impact on the public health, health care, housing and social service facilities in local communities;

p. adequate funding for basic biomedical, epidemiological, psychosocial and other AIDS-related research. The National League of Cities supports the recommendations of the National Academy of Sciences that $ 1 billion per year be dedicated to AIDS research, and

q. we support an accelerated process for approved drugs to treat persons with AIDS.

## APPENDIX F

**Listed below are recommended articles and books that will provide local officials with current data on AIDS and public safety personnel. Most, but not all, were used as a source of information for this report.**

### ARTICLES


**"AIDS: At The Dawn Of Fear."** U.S. News & World Report, 102, No. 1 (January 12, 1987), 60-69.

Crowley, Geoffrey. **"AIDS The Next Ten Years."** Newsweek, CVX, No.26 (June 25, 1990), 20-27.

Emery, George L. **"Contaminated Evidence Disposal: What are the Rules?"** The Police Chief, LVI, No. 12 (December 1989), 22-23.

Forst, Martin, Moore, Melinda and Crave, Graham. **"AIDS Education for California Law Enforcement."** The Police Chief LVI, No. 12 (December 1989), 25-28.

Gibbons, Jean. **"Work in the age of AIDS."** Washington Business Journal, (June 12, 1989) 10.

**"Inside An AIDS Colony."** U.S. News and World Report, 108, No.4. (January 29, 1990) 20-26.

Jones, Walter J. and John, James A. **"AIDS in the Workplace: Legal and Policy Consideration for Personnel Managers."** Review of Public Personnel Administration, 9, No. 3 (Fall 1989), 3-4.

Kaplan, Mark S. **"AIDS: Individualizing a Social Problem."** Society, 27, No. 2 (January/February 1990), 4-7.

Kenny, Jo. **"Why Coping with AIDS is a City Issue."** Western City, League of California Cities, (September 1988), 16-18.

Kosterlitz, Julie. **"Is Support For AIDS Slipping?"** National Journal, 22, No. 22 (June 2, 1990), 1351.

Marchner, Carol. **"AIDS and Employees."** Quality Cities, 61, No. 9 (March 1988), 20-21.

Matlack, Carol. **"Gay Clout."** National Journal, 22, No. 1 (January 6, 1990), 16-19.

**"Models for Management."** The Police Chief, 54 No. 12 (December 1987), 39-43.

**"New AIDS Report Calls For Stronger Prevention Programs."**

NewsReport, 40, No. 7 (July 1990), 2-5.

Pavlak, Thomas J. **"Stigmatization of Persons with AIDS: Results of a Survey of Public Sector Personnel Managers."** Socio-Economic Planning Sciences, 23, No. 4 (Fall 1989), 195-201.

Pedrotti, Dean and Williams, Irvine. **"Infectious Disease and the Risk of Lawsuit."** Firehouse, 15, No. 2 (February 1990) 20,22.

Pedrotti, Dean and Williams, Irvine. **"Stocking the Fire Station for Infection Control."** Firehouse, 14, No. 12 (December 1989) 26, 28.

Pedrotti, Dean and Williams, Irvine. **"USFA Forum Recommendations on Communicable Diseases."** Firehouse, 14, No. 10 (October 1989) 18, 20-21.

Quarrelles, Jamie C. **"Aids: The Local Government Response."** Virginia Town and City, 23, No. 5 (May 1988), 7-9.

Rumsey, Sunny. **"AIDS What Risk To Save A Life."** Fire Engineering, 140, No. 6 (June 1987), 32-38.

Schachter, Victor. **"Legal AIDS: An Enlightened Corporate Policy."** Across The Board, 24, No. 9 (September 1987), 40-43.

**"Screening for HIV: Focus on Women and Infants."** NewsReport, 40, No. 7 (July 1990), 6-8.

Sheppard, Dick. **"AIDS in the Workplace."** Worklife. 2 No. 2 (Summer 1989), 25.

Smith, Kenneth. **"AIDS and Municipal Employees."** Alabama League of Municipalities, 45, No. 7 (January 1988), 16-17.

**"The Future of Gay America."** Newsweek, CXV, No. 11 (March 12, 1990) 20-25.

Velasquez, Mike, and Mitchell, Marilyn. **"Emergency Response To Questions on AIDS."** Fire Engineering, 141, No. 5 (May 1988), 43-48.

## BOOKS

Aaron, Anne, and Browning, Iben. **AIDS The Economic of AIDS.** Albuquerque, New Mexico: Sapiens Press. 1988.

Abt Associates Inc,. **An Annotated Bibliography of Scientific Articles on AIDS for Policymaker's.** Cambridge, Massachusetts: For Office of the Assistance Secretary for

Health Planning and Evalution. 1987.

California Fire Fighter Foundation. **Public Safety Workers and AIDS.** (formerly: Emergency Workers and the AIDS Epidemic), 4th Edition, May 1989.

Center for Disease Control. "Recommendations For The Prevention OF HIV Transmission In Health Care Settings," **Morbidity and Mortality Weekly Report: Supplement.** August 21, 1987.

Glenney, Jeff. **Southern California Law Review.** Los Angeles, California: Law Center University of Southern California. September 1989.

Hammett, Theodore M. 1988 Update: **AIDS in Correctional Facilities.** Washington, D.C.: National Institute of Justice. June 1989.

Hammett, Theodore M. **AIDS in Correctional Facilities: Issues and Options.** Washington, D.C.: National Institute of Justice. April 1988.

Hunt, Dana Eser. **AIDS in Probation and Parole.** Washington, D.C.: National Institute of Justice. June 1989.

League of California Cities. **Municipal AIDS Policies and Programs, Resource for City Officials.** Sacramento, California: League of California Cities. July 1989.

New York Business Group on Health, Inc. **AIDS Education In The Workplace: What Employees Think.** New York, New York: NYBGH. 1990.

Public Technology, Inc. **Local Government & AIDS.** Washington, D.C.: Public Technology, Inc. and National League of Cities. 1988.

Puckett, Sam and Emery, Alan. **Managing AIDS in the Workplace.** Addison-Wesley Publishing Co., August 1988.

Rowe, Mona and Ryan, Caitlin. **A Policymaker's Guide on AIDS.** Washington, D.C.: The Intergovernmental Health Policy Project, The George Washington University. 1989.

Schecter, Victor and Susan von Seeburg. **AIDS: A Managers Guide.** San Francisco: Executive Publications, 1988.

United States General Accounting Office. **AIDS Forecasting-Undercount of Cases and Lack of Key Data Weaken Existing Estimates.** Washington, D.C.: United General Accounting Office. 1989.

U.S. Department of Health and Human Services, and Public

Health Service, and Centers for Disease Control, and National Institute for Occupational Safety and Health, and Center for Infectious Diseases. **Guidelines For Prevention Of Transmission Of Human Immunodeficiency Virus And Hepatitis B Virus To Health-Care And Public-Safety Workers.** Washington, D.C.: U.S. Government Printing Office. February 1989.

## SAMPLE AIDS POLICIES


Page

**PHILADELPHIA, PENNSYLVANIA** . . . . . 38
Emergency Medical Services Personnel
population: 1,688,210

**MOBILE, ALABAMA FIRE DEPARTMENT** . . . . . 39
Communicable Disease Policy
population: 200,452

**PHOENIX, ARIZONA FIRE DEPARTMENT** . . . . . 53
Infection Control Policy
population: 764,911

**WASHINGTON, D.C. METROPOLITAN POLICE DEPARTMENT** . . 56
AIDS Response Plan
population: 620,000

**NEWTON, KANSAS** . . . . . 67
Employer Task Force on AIDS
population: 17,000

# AIDS AVOIDANCE MEASURES FOR EMERGENCY MEDICAL SERVICES PERSONNEL ON DUTY

## PHILADELPHIA

### I. USE OF PROTECTIVE EQUIPMENT

Gloves or protective equipment are not needed for the performance of routine EMS duties which do not require direct contact with blood/body fluids.

In the following special circumstances OBSERVE THESE PRECAUTIONS:

1. **Cardiopulmonary resuscitation (CPR).**
   Use the Loerdal face mask.
   No one has ever become infected with the AIDS virus by performing CPR. Therefore, you should not hesitate to perform CPR when indicated.
2. **Contact with blood or body fluids.**
   Wear disposable latex gloves. Wash hands with soap and water before and after removing gloves.
3. **Never recap needles or catheters.**
   Dispose of used needles or catheters by placing them in the puncture proof containers provided specifically for this purpose. These containers, when full, must be autoclaved and then incinerated.

### II. IF CONTACT WITH BLOOD/BODY FLUIDS OCCURS

**OBSERVE THESE PRECAUTIONS:**

1. Contact of Blood/Body Fluids with Your Unbroken Skin
   Immediately use 70% alcohol pads or rubbing alcohol to remove blood/body fluid.
   As soon as possible, thoroughly wash the exposed area with soap and water.

2. Contact of Blood/Body Fluids with Your Broken Skin (Cut, Puncture Wound or Rash)
   Immediately use 70% alcohol pads or flush with rubbing alcohol to remove blood/body fluid.

   As soon as possible, thoroughly wash the exposed area with soap and water.
   Report to the Compensation Clinic, 216 North Broad Street, during regular business hours (8:00 a.m. to 5:30 p.m.). You will be seen without an appointment. At the Compensation Clinic, medical personnel will conduct appropriate evaluations, including testing for the AIDS virus and the hpatitis B virus, and will provide you with all necessary information and follow-up.

3. Contact of Blood/Body Fluids with Your Mouth or Eye
   Flush eye with water.
   Wash mouth out with water. Rinse mouth with mouthwash.

4. Blood/Body Fluid on Clothing
   Clothing contacted by blood or body fluids should be commerically dry cleaned or machine-laundered in hot water and machine-dried at high temperatures.

5. Vehicle Soiled with Blood/Body Fluids
   Any vehicle soiled with blood/body fluids should be cleaned as soon as possible with a solution of 1 part household bleach (such as Clorox) with 9 parts of water.

# FIRE DEPARTMENT COMMUNICABLE DISEASE POLICY

ATTENTION: **ALL PERSONNEL**

## I. PURPOSE

To advise all Fire Department Personnel of routine precautionary measures and establish guidelines to be followed in the event of exposure of possible exposure to a communicable disease.

## II. EXPOSURE PREVENTION PRACTICES

The following shall be adhered to when a communicable disease is suspected or when there may be an exposure to blood, body fluids, or excreta:

A. Ask patient for communicable disease history during patient evaluation.

B. Disposable gloves should be work when there is the possibility of direct exposure.

C. Contaminated needles are to be handled with extreme care and should not be recapped. They should be disposed of in a safe manner (which should be in a puncture-proof container that can be discarded at a hospital).

D. A mechanical devise should be used whenever possible for respiratory assistance or resuscitation.

E. Disposal filter masks should be worn by patients and/or rescue personnel when dealing with patients who are actively coughing or suspected of having an airborne transmitted disease.

F. Handwashing with soap and water or an approved substitute is to be done after each patient contact.

G. Clothing and equipment contaminated with blood, other body fluids, or excreta shall be immediately changed and decontaminated.

H. Dispose of contaminated supplies in a plastic bag or container in an approved manner.

I. Report all exposures to communicable diseases as well as suspected exposures by filing "Communicable Disease Contact Report." (Appendix III)

- o Fire Department Chain of Command
- o Mobile County Personnel Board
- o Receiving Hospital - Funeral Home

## III. DECONTAMINATION PRACTICES

A. Equipment which has been contaminated with blood or other body fluids of patients suspected or known to have a communicable disease shall be decontaminated by personnel wearing rubber gloves as follows:

1. Large rescue equipment such as a traction splint, backboards, blood pressure cuffs, Stokes stretchers, K.E.D. boards, M.A.S.T. suits, etc., should be washed with a disinfectant-detergent solution and hot water (140° or above) and air dried immediately upon return to quarters.

2. Delicate equipment such as scope/defibrillators, radios, resuscitators, and aspiration machines shall be wiped down with a 1:10 dilution of household bleach (e.g. Clorox) in water immediately upon return to station for 30 seconds duration.

3. The mask and positive pressure ventilating head from the resuscitator shall be washed with a disinfectant-detergent solution and hot water and air dried. The bag-mask valve device should be washed with a

disinfectant-detergent solution and hot water after each use and air dried. Laryngoscope blades, Magill forceps, and hemostats will be disinfected in the same manner.

B. Clothing which has been contaminated with blood or other body fluids of patients suspected or known to have a communicable disease must be decontaminated immediately as follows:

1. Contaminated clothing should be changed as soon as possible, including turnout gear. Turnout gear should be washed with a disinfectant-detergent solution and air dried.

2. Personnel should use examination gloves when washing contaminated clothing.

3. Clothing (when removed) should be pre-washed with disinfectant-detergent solution and hot water in the apparatus floor sink, then taken home to be laundered in a normal manner. Air drying or machine drying assists in the decontamination process.

4. Boots, leather or turnout type, may be brushed-scrubbed with soap and hot water to remove contamination.

5. Passenger spaces and seats in vehicles and on apparatus should be scrubbed with a disinfectant, detergent solution and hot water when in contact with contaminated clothing or turnout gear, then thoroughly rinsed and dried.

6. Plastic bags of a general purpose type should be used to transport contaminated clothing or other articles that have come into contact with body fluids of a suspected or known communicable disease victim.

7. Personnel are reminded that the skin provides a barrier for prevention of

communicable diseases. However, one should wash all contact areas with any means available as soon as possible after contact.

C. DISPOSAL:

Supplies that have been contaminated with blood or other body fluids of a suspected or known carrier of a communicable disease shall be disposed of as follows:

A. All contaminated supplies, except sharp instruments, should be placed in a general purpose plastic bag and delivered to the Alabama State Department of Forensic Science for disposal.

B. Sharps (needles, glass vials) should be placed in a more sturdy container and disposed of in the manner previously stated.

D. INVESTIGATION, TREATMENT AND REMEDIAL PRACTICES

The attached Appendixes I, II and III, hopefully, provide some guidance for actions to the following while still complying with laws regarding confidentiality:

A. Investigation and feedback of information to personnel possibly exposed to communicable disease; and

B. Isolation, protection, and treatment of personnel who have contracted communicable diseases.

The following information is provided as a quick reference guide to the common communicable diseases that pre-hospital care personnel may encounter.

A communicable disease should be suspected when fever, skin rash and/or weeping lesions, jaundice, diarrhea, or cough are present.

The following chart by no means gives complete information or recommendations regarding the diseases.

You are encouraged to call your agency's appropriate office if you have any further questions.

| | EXPOSURE CATEGORY | ACTION CATEGORY |
|---|---|---|
| Level I | Contact limited to merely being in the presence of a person suspected of having a communicable disease. | A - No special action required. |
| Level II | Contamination of clothing or equipment by victim's body fluids | B - Decontamination. Complete Communicable Disease Contact Report. |
| Level III | Exposure of skin/mucous or conjunctival membranes to victim's body fluids, i.e., blood, vomitus, feces. This category includes ingestion of "possible" contaminated food, needle puncture, and human bites. | C - Special action indicated; complete Communicable Disease Contact Report; and take appropriate remedial action. |

## COMMUNICABLE DISEASES QUICK REFERENCE CHART

| DISEASE | INCUBATION PERIOD | HOW CONTRACTED | SIGNS AND SYMPTOMS | WHAT TO DO IN CASE OF EXPOSURE DURING A RESCUE | | WHAT TO DO IN CASE OF EXPOSURE TO FELLOW EMPLOYEE | |
|---|---|---|---|---|---|---|---|
| | | | | Exposure Category | Action Category | Exposure Category | Action Category |
| Acquired Immune Deficiency Syndrome (AIDS) | Maybe up to five years | Blood-to-blood exposure; sexual contact | May not be detected by pre-hospital responders. Be alert in any case where open sores are present. The high risk population are I.V. drug abusers, homosexual and bisexual men, and hemophilliacs. | I<br>II<br>III | A<br>B<br>B, C | I<br>II<br>III | C<br>C<br>C |
| Hepatitis, Viral (Hepatitis A) | 15 - 50 days, average 28-30 days | Person-to-person spread by fecal-oral route. Ingestion of contaminated food or water. | Onset is usually abrupt, with fever malaise, loss of appetite, nausea, and abdominal discomfort, followed within a few days by jaundice. | I<br>II<br>III | A<br>B<br>B | I<br>II<br>III | A<br>B<br>B, C |
| | | | | Immune serum globulin (ISG) may be recommended by physician based on extent of exposure. | | | |
| Hepatitis B | 45-160 days days, average 60-90 days. | Percutaneous or mucous membrane inoculation of blood or blood products from an infected person. Sex transmis. | Onset is usually gradual, with loss of appetite, vague abdominal discomfort, nausea, and vomiting often progressing to jaundice. | I<br>II<br>III | A<br>B<br>B, C | I<br>II<br>III | A<br>B<br>B, C |
| | | | | Physician may recommend HBIG and Hepatitis B vaccine based on extent of exposure. | | | |

## COMMUNICABLE DISEASES QUICK REFERENCE CHART

| DISEASE | INCUBATION PERIOD | HOW CONTRACTED | SIGNS AND SYMPTOMS | WHAT TO DO IN CASE OF EXPOSURE DURING A RESCUE | | WHAT TO DO IN CASE OF EXPOSURE TO FELLOW EMPLOYEE | |
|---|---|---|---|---|---|---|---|
| | | | | Exposure Category | Action Category | Exposure Category | Action Category |
| Hepatitis Non A, Non B Syndrome (AIDS) | 14-180 days, average | Blood transfusion | Onset usually gradual, with loss of appetite, vague abdominal discomfort, nausea, and vomiting. | I<br>II<br>III | A<br>B<br>C, | I<br>II<br>III | A<br>B<br>C |
| Herpes Simplex Virus, Type I | | Direct contact w/ mucous membrances. skin lesions. | Cold sore, ulcers in mouth; most infect. are reactive. of lat. virus. | I<br>II<br>III | A<br>B<br>B | I<br>II<br>III | A<br>B<br>B |
| Meningitis, Aseptic | 2-21 days dependent on agent. | Varies with the specific infections agent. | Sudden onset of fever with headaches, stiff neck. | I<br>II<br>III | A<br>A<br>A | I<br>II<br>III | A<br>A<br>A |
| Meningitis, II. Influenza (Is the most common bact. meningitis in children 2 months to 5 years in United States) | Probably short-within 2-4 days | Droplet infection and discharges from nose and throat. | Onset usually sudden with fever, vomiting lethargy, and meningeal irritation consisting of bulging frontanelle in infants or stiff neck and back in slightly older children. | This disease is unusual in persons over the age of 5 years.<br>I<br>II<br>III | <br>A<br>B<br>B | Not applicable | |

COMMUNICABLE DISEASES QUICK REFERENCE CHART

| DISEASE | INCUBATION PERIOD | HOW CONTRACTED | SIGNS AND SYMPTOMS | WHAT TO DO IN CASE OF EXPOSURE DURING A RESCUE | | WHAT TO DO IN CASE OF EXPOSURE TO FELLOW EMPLOYEE | |
|---|---|---|---|---|---|---|---|
| | | | | Exposure Category | Action Category | Exposure Category | Action Category |
| Meningitis, Meningococcal | 2-10 days, average 3-4 days. | Person-to-person by droplet spread and discharges from nose and | Sudden onset of fever, headache, nausea, vomiting, stiff neck. | I<br>II<br>III | A<br>B<br>B, C | Prophylaxis and observations as recommended by physician. Disinfection of objects/articles contaminated with nose and throat discharges. Ventilate living/ sleeping quarters. | |
| | | | | Prophylaxis and observations as recommended by physician. | | | |
| Pediculosis (Lice) | 7-14 days. | Direct contact w/ infested person; contact w/infested articles or objects. | Infestation of the scalp or the hairy parts of the body including eyebrows and clothing with adult lice, larvae, or eggs. | No special action indicated for any category. | | When infestation is evident, all suspected infested clothing, bedding, and personal articles should be thoroughly washed in hot water (140° or dry cleaned. The interior of the premises suspected to be infested should be thoroughly cleaned and vacuumed. | |

## COMMUNICABLE DISEASES QUICK REFERENCE CHART

| DISEASE | INCUBATION PERIOD | HOW CONTRACTED | SIGNS AND SYMPTOMS | WHAT TO DO IN CASE OF EXPOSURE DURING A RESCUE | | WHAT TO DO IN CASE OF EXPOSURE TO FELLOW EMPLOYEE | |
|---|---|---|---|---|---|---|---|
| | | | | Exposure Category | Action Category | Exposure Category | Action Category |
| Syphilis | 10-90 days, usually 21 days. for appearance of chancre (lesion). | Direct contact with infectious lesion. Sexual transmission. | Primary (1st stage): Presence of a painless lesion in area of contact.<br><br>Secondary: Varies from rash on palms of of hands and soles of feet and/or generalized rash. | I<br>II<br>III | A<br>B<br>B | Not transmitted through the usual casual workplace setting. | |
| Tuberculosis, Pulmonary | From infection to primary phase: 4-6 weeks. May be many years before secondary disease. | Inhalation of aerosol of respiratory secretions of an UNTREATED person. | Cough, fatigue, fever, weight loss, hoarseness, chest pain, and blood in sputum may occur but are often absent until the disease is advanced. | I<br>II<br>III | A<br>B<br>C | Health Programs Coordinator should be notified for all exposure categories | |

**MOBILE FIRE DEPARTMENT**
**COMMUNICABLE DISEASE CONTACT REPORT**

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**INSTRUCTIONS:** Complete two copies whenever exposed, or suspect exposure, to a communicable disease while performing city duties. Send one (1) copy to the Mobile County Personnel Board, Attention: Shannon Weekly, P. O. Box 447, Mobile, Alabama 36601. One copy is to remain in the fireman's personnel file in the Fire Chief's Office. [Keep a copy of the contact report for your own files.]

**INCIDENT INFORMATION**: Date of possible exposure:_____ Time:_____
Location: _____ Transaction No:_____

**PERSONS EXPOSED**: Fireman/Paramedic Exposed:_____
Age:____ Current Health Status: Healthy___ Not Healthy_____ List other known exposed persons: _____
Witnesses:_____

**PATIENT INFORMATION** (Patient information must be voluntarily given.)
Name of suspected diseased person:_____ Age:_____
Sex:_____ Health Status: (Explain):_____
Drug User_____ Homosexual or Bisexual _____ Hemophiliac_____
Patient Location: (i.e. residence, street corner, etc.)_____
_____
Patient Destination: (i.e. hospital, funeral home, etc.)_____
_____

**DISEASE INFORMATION**: Name of Suspected Disease: AIDS ____ Meningitis ____
Tuberculosis ___ Hepatitis A ___ Hepatitis B _____ Other:_____
Confirmed? Yes ___ No ___ If so, when, and by whom?_____
_____

**EXPOSURE INFORMATION**
Nature of Exposure: (i.e. Blood to blood, needle stick, ingestion, inhalation, absorption. etc.)_____
_____
Contaminant: (i.e. Blood, mucus, semen, saliva, vaginal secretions, etc.)
_____
Narrative Explanation:_____
_____
_____

**SAFETY ACTION TAKEN**
Gloves _____ Goggles _____ Gown/Fire Coat _____ Mask _____
Equipment used:_____ Decontaminated?_____ Destroyed? _____
When and by whom:_____
Test and Test Results (If Suggested By A Physician):_____
_____
Additional testing or recommended action: _____
County Health Department Notified: Yes:_____ No_____ Date:_____
Supervisor's Signature: _____ Date:_____
Exposed's Signature:_____ Date:_____
Fire Chief's Signature_____ Date_____

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**IMPORTANT NOTE**: Report must be filed within 72 hours of incident.

CDR:12/18/87

COMPARISON CHART FOR HEPATITIS A, HEPATITIS B, HEPATITIS NON A, NON B

| | HEPATITIS A | HEPATITIS B | HEPATITIS NON A, NON B |
|---|---|---|---|
| Agent | HAV (Hepatitis A virus). | HBV (Hepatitis B virus). | Unknown (may be more than one agent. |
| Transmission | Fecal-oral: Contaminated food and water. | Percutaneous or mucous membrane inoculation of of blood or blood products from an infected person. Sexual transmission. | Transfusions (probably similar to HBV) |
| Incubation | 15-50 days (average 25-30 days). | 45-160 days (average 60-90 days). | 40 days average |
| Onset | Sudden | Incidious | Unknown |
| Sources | Feces. | Blood products; possible saliva, semen. | Blood; other sources uncertain. |
| Communicability | Two weeks prior to onset of jaundice. | Several weeks before onset of jaundice to as long as blood test is positive for antigen. | Not known |
| Treatment | None specific, supportive. No carrier state. | None specific, supportive | None specific, supportive. |

COMPARISON CHART FOR HEPATITIS A, HEPATITIS B, HEPATITIS NON A, NON B

| | HEPATITIS A | HEPATITIS B | HEPATITIS NON A, NON B |
|---|---|---|---|
| Prophylaxis | Immune serum globulin (ISG). | Hepatitis B vaccine, Hepatitis B immune globulin (HBIG). | Not Known agent. |
| Symptoms | Abrupt onset with fever, malaise, anorexia, abdominal discomfort, jaundice, vomiting, hepatomegaly. Chronic liver disease with cirrhosis not documented. Fulminating liver disease with coma rare. With acute hepatic failure, mortality rates are 65-75%. Severity increases with age. | Insidious onset with anorexia, malaise, abdominal discomfort, jaundice, and arthralgias. Occasionally progresses to chronic liver disease and cirrhosis. With acute hepatic failure, mortality rate is 65-75%. Severity increases with age. | Essentially same as for Hepatitis B. With acute hepatic failure, mortality rate 90-95%. Severity increases with age. |
| Synonyms | Infectious, epidemic, short incubation hepatitis. | Serum, antigen positive, long incubation hepatitis. | "Post-transfusion hepatitis" (has represented 90% of post-transfusion hepatitis in recent years). |

1. ANTIBODY - A protein that is formed in response to an aitigen. Some antibodies protect against reinfection with the same bacteria, virus, etc.

2. ANTIGEN - Foreign material against which antibodies are made. May be a microorganism or a protein such as a vaccine.

3. BACTERIA - A microorganism capable of causing disease. Many diseases are caused by bacteria, but, conversely, many bacteria live within humans without a negative effect.

4. CARDINAL SIGNS OF COMMUNICABLE DISEASES - Fever, skin rash and/or weeping lesions, jaundice, diarrhea, and cough.

5. CARRIER STATE - A carrier state exists when a person or animal harbors a specific infectious agent in the absence of observable clinical disease.

6. CHRONIC CARRIER - A person with a positive carrier state over a prolonged space of time.

7. CLEANING - The removal by scrubbing and washing, as with hot water, soap or suitable detergent, or by vacuum cleaning of infectious agents and of organic matter from surfaces on which and in which infectious agents may find favorable conditions for surviving.

8. COMMUNICABLE DISEASES - Illnesses due to specific infectious agents which arise through transmission of those agents from an infected person, animal, or object to a susceptible host, either directly or indirectly.

9. CONTACT - A person or animal that has been in such association with an infected person or animal or contaminated environment so as to have had opportunity to acquire the infective agent.

10. CONTAMINATION - The presence of an infectious agent on a body surface; also, on or in any other object. Contamination on a body surface does not imply a carrier state.

11. DECONTAMINATION - A process or method whereby an object or material is freed of biological contaminants and rendered safe for human handling.

12. DISINFECTION - Killing of infectious agents outside the body by chemical or physical means directly applied.

13. FOMITE - Any nonliving substance that transmits infectious diseases, e.g., dirty needles, contaminated Kleenex.

14. FUNGUS - A member of the plant kingdom which may cause infections. It is most commonly an infectious agent in immuno-compromised hosts or when the normal bacterial population is suppressed.

15. HOST - The organism from which a parasite or infectious agent obtains its nourishment.

16. IMMUNO-COMPROMISED/IMMUNE DEFICIENCY - A state in which the immune systems of the organism are unable to perform in their normal manner to resist infectious agents.

17. INCUBATION PERIOD - The time interval between exposure to an infectious agent and the appearance of the first sign or symptom of the disease.

18. INFECTIOUS DISEASE - A clinically apparent disease of man or animal resulting from an infectious agent.

19. INFECTIOUS PERIOD - The time from which an individual is first able to transmit an infectious agent to the time when transmission is no longer possible.

20. INFESTATION - Parasitic attack or subsistence on the skin and its appendages, as by insects, mites, lice, or ticks.

21. PARENTERAL - Injection of substances into the body through the skin, usually with a hypdermic needle.

22. PROPHLAXIS - Preventive treatment.

23. SUB-CLINICAL INJECTION - Infection which occurs without observable signs or symptoms.

24. VACCINATION (IMMUNIZATION) - The exposure of patients to innocuous portions or products of infectious agents that stimulate their immune system in a prophylactic manner.

25. VECTOR - A living transporter and transmitter of the causative agent of disease. Usually is an arthropod, e.g., mosquitoes, lice, fleas, ticks, and mites.

26. VERTICAL TRANSMISSION - The transmission of an infectious agent from the mother to the fetus or infant at or before birth.

27. VIRUS - An infectious microorganism only able to replicate within a living cell.

DRAFT

## PHOENIX FIRE DEPARTMENT INFECTION CONTROL POLICY

Phoenix Fire Department recognizes the potential exposure of its members to communicable diseases in the performance of their duties. In the emergency care setting, the infectious disease status of patients is frequently unknown by fire department personnel. All patients must be considered infectious. Blood and body fluid precautions must be taken with all patients.

To minimize the risk of exposure, the Phoenix Fire Department will provide its members with proper protective equipment including disposable gloves, face masks, gowns and eyeglasses, and will provide necessary cleaning and disinfecting supplies. Phoenix Fire Department will also provide initial instruction and continuing education in preventative health care practices so that firefighters possess a basic awareness of infectious diseases, understand the risks and severity of various types of exposures and exhibit proper skills in infection control.

Standard prophylaxis medical treatment will be given to exposed members and necessary immunizations will be made available to protect firefighters from potential exposure to infectious disease.

Fire Department members will contact the fire department infection control representative after any actual or suspected exposure to a contagious disease. The infection control representative will contact the hospital to initiate patient follow up and determine the need for treatment of the exposed individual. A contagious disease exposure tracking system is a component of the medical records system that is maintained for each member.

The Phoenix Fire Department believes that it's members have the right to be fully informed if a patient is found to carry a communicable disease and if a probable exposure occurred. The responsibility for informing the Phoenix Fire Department should rest with the medical institution receiving the patient and should occur as soon as possible after the medical institution becomes aware of the condition. This is dependent, however, on legal constraints which have not been completely resolved.

The Phoenix Fire Department also believes that infectious disease exposure should be considered an occupational health hazard, and supports the presumption that contracting a contagious disease should be considered an occupationally related condition.

## INFECTION CONTROL - PROTECTIVE MEASURES IN THE FIELD

This procedure outlines protective measures Fire Department personnel should take when treating patients. These protective measures should be taken even if the patient does not have symptoms of a disease. It will be the employees responsibility to initiate protective measures.

### INFECTIOUS DISEASES - TRANSMISSION

Infectious substances are transmitted via an infected person's body fluids (i.e. saliva, sputum, blood, urine, vomit and fecal matter). Generally the human skin is a barrier against exposure to infectious contaminants. If, however, the skin has open sores, cuts, or abrasions, this protective barrier is broken. Patients who cough or sneeze toward treatment personnel also increase risk of exposure. Contact with the patient's blood or other body fluids further increases risk. A puncture wound resulting from an I.V. needle or other item that has been in contact with the patient's blood or body fluids possess a significant exposure risk to treatment personnel.

### PROTECTIVE MEASURES

- Ask patients to turn their head away and cover their mouth/nose when coughing or sneezing.
- Wear a surgical mask when appropriate.
- Wear gloves when treating all patients.
- Limit exposure time.
- Minimize the number of treatment personnel in the area.
- Avoid direct contact with saliva, sputum, tears, sweat, blood, urine, feces, or vomit.
- Wear eye protection when appropriate (for example, during intubation or resuscitation).
- Do not wipe your nose, mouth or eyes after patient contact until you wash your hands.
- Thoroughly wash your hands as soon as possible.
- Use extreme caution when handling and disposing needles and other sharp objects. Use the ZORRO stick or other safe needle resheathing technique when a sharps container is not immediately available.
- Properly disinfect equipment after each use and again during weekly inspections.
- If you think you have had an infectious exposure, clean the affected area to the body immediately.

INFECTION CONTROL - PROTECTIVE MEASURE IN THE FIELD (CONTINUED)

HAND WASHING

The Center for Disease control states that "Hand washing before and after contact with patients is the single most important means of preventing the spread of infection."

Washing your hands after each patient is a must. Use the patients own wash room or public facilities when possible. Use the soap and alcohol dispensers mounted on ambulance and fire apparatus when other wash facilities are not available.

Phoenix Fire Department recommends hand washing take a minimum of 10 seconds to properly rid the hands of protein mater, blood, secretions and other contaminants picked up while handling patients. Vigorous scrubbing is essential.

The following is one suggested method to wash hands:

1. Wet hands up to two to three inches above wrists.
2. Apply hand-cleansing agent. Various agents and soaps are furnished for station use.
3. Rub hands to work up a lather.
4. Using a rotating motion, apply friction to all surfaces of hands and wrists, including backs of hands, between fingers and around and under nails. Interlace fingers and rub up and down; continue for 15 seconds.
5. Holding hands downward, rinse thoroughly, allowing the water to drop off fingertips.
6. Repeat procedure.
7. Dry hands thoroughly with a paper towel.
8. Turn off faucet using a clean paper towel so as not to re-contaminate your hands on the dirty faucet handle.

Metropolitan Police Department

WASHINGTON, DC

# AIDS RESPONSE PLAN

## A Plan To Address Problems and Issues Concerning AIDS and How Police Officers Should Handle Them

May 1988

**GOAL # 1**

To disseminate information promptly to ensure that members have accurate and current information available to them as soon as possible.

**Objective #1**

To create an AIDS Information Bulletin

Purpose: To provide significant or pertinent information on the subject of AIDS, to serve as a transmittal for department or outside agency publications, or to announce the availability of publications on the subject.

**Objective #2**

To disseminate the "Surgeon General's Report on Acquired Immune Deficiency Syndrome."

Purpose: To provide members with an easy-to-read but comprehensive treatment of AIDS.

**Objective #3**

To disseminate the film "AIDS and Your Job."

Purpose: To provide members with information and recommendations for emergency service workers. The film is produced by the Centers for Disease Control and is 13 minutes long. It will be shown at roll calls.

**Objective #4**

To edit are re-release the MPD film "AIDS: The Known Facts."

Purpose: To provide members with information and recommendations pertinent to law enforcement.

**Objective #5**

To implement the Commission of Public Health to designated MPD personnel so that these trained members can in turn provide continuous educational services to members of their organizational elements.

GOAL #2

To issue policies and procedures that reflect due consideration of the safety of our members, the best medical evidence, and the concerns of the community.

Objective #1

To publish a Special Order on "Protective Equipment".

Purpose: To better ensure the safety and welfare of members, to ensure consistency in the use of protective equipment, and to instill in members a sensitivity to legitimate concerns raised when protective equipment is used.

Objective #2

To study the feasibility of storage containers for syringes and needles.

Purpose: To reduce the occurrence of needle sticks by providing a safe container for syringes and needles that must be stored for evidence or for disposal.

Objective #3

To study the feasibility of storage containers for syringes and needles.

Purpose: To reduce the occurrence of needle sticks by providing a safe container for syringes and needles that must be stored for evidence or for disposal.

Objective #4

To explore alternative field searching techniques.

Purpose: To reduce the likelihood of needle sticks which most often occur during the searching of prisoners.

Objective #5

To develop collection, handling, and storage procedures for possibly contaminated evidence.

Purpose: To ensure that Mobile Crime and Crime Scene Search personnel have adequate safeguards while handling evidence that is possibly contaminated.

* * * * *

GOAL #3

To keep abreast of protective equipment that is on the market to ensure that department issued equipment is sufficiently protective, efficient, and cost effective.

Objective #1

For the Uniform and Equipment Board to designate a sworn member to monitor and report on developments in the area of protective equipment.

Purpose: To ensure that the department, through the Uniform and Equipment Board, has a systematic method of keeping abreast of developments in the area proposals for and acquisition of new equipment.

* * * * *

GOAL #4

To provide mechanisms to respond immediately to the needs and concerns of members to ensure that they are served promptly and satisfactorily.

Objective #1

To establish an AIDS Medical Desk.

Purpose: To provide members with a mechanism, on a 24-hour, seven-day-a week basis, by which they can contact a member of the Board of Police and Fire Surgeons for medical advice and counselling with respect to AIDS- related problems or situations.

Objective #2

To implement procedures for handling occupational exposures.

Purpose: To provide members with a means for being tested and, if necessary, tested as a result of occupational exposures to blood or other body fluids; and to provide a means for the examination and testing of individuals from whom the member received the exposure.

* * * * *

GOAL #5

To disseminate AIDS Information to prisoners who are considered to be sick.

Purpose: To assist the Commission of Public Health in its effort to educate the public. Since the Morals Division processes many drug and prostitution arrests, members of that organizational element will distribute publications furnished by the Commission of Public Health to prisoners who have been arrested for their involvement in drug abuse or prostitution.

* * * * *

GOAL #6

To designate knowledgeable and involved personnel to serve as a resource and consultative body to enable the department to meet the goals of the plan, the interests of our members, and the interests of the community.

Objective #1

To establish an AIDS Resource Group.

Purpose: To ensure that the best information is being disseminated and to assist with the implementation of the AIDS Response Plan. The group, which will be chaired during meetings by the Chairman of the Board of Police and Fire Surgeons, will be a network of civilian and sworn members with expertise in public health, medicine, technical areas such as protective equipment, education, planning, and public relations. It will also consist of officers familiar with street operations and a representative from the community.

# Protective Equipment

PURPOSE:

The purpose of this order is to establish policy and procedures for the wearing of protective equipment in certain circumstances in order to:

- better ensure the safety and welfare of members by further reducing the low risk of contracting communicable diseases; and promoting hygienic practices;
- ensure consistency in the use of protective equipment; and
- instill in members a sensitivity to legitimate concerns raised when protective equipment is used as a barrier to direct contact between police officers and citizens.

POLICY

A. Standards for Wearing Protective Equipment.

1. Mandatory Wearing of Protective Equipment.

Members shall wear appropriate protective equipment:

a. While processing crime scenes or handling situations, such as a traffic accident, where there is a presence of body fluids, especially blood, and/or contaminated materials; and

b. When they encounter individuals, as well as evidence and personal property associated with them, who:

(1) Are bleeding or excreting other body fluids.

(2) Have open sores;

(3) Have body fluids on their clothing; or

(4) Appear to be infected with parasites, such as lice.

2. Optional Wearing of Certain Protective Equipment.

a. By the nature of police work, members regularly encounter unsanitary, hazardous, and possibly infectious conditions where body fluids may not be readily apparent or even present. for hygienic and safety reasons and to reduce the potential of exposure to blood or other body fluids, members may wear appropriate protective equipment in the following circumstances:

(1) To search and process prisoners;

(2) To handle individuals who are outwardly unsanitary;

(3) When coming into physical contact with individuals, as well as evidence and personal property associated with them, who claim, are reasonably believed, or are known to have a communicable disease, and there is any risk of coming into contact with blood or other body fluids;

(4) To process, or assist in the processing of, crime scenes and evidence, and

to conduct searches of areas that are hazardous or hidden from view; and

(5) To handle a violent altercation or a situation where, by the nature of the assignment or the belligerent behavior of individuals on the scene, the member expects that the event will escalate into an altercation where bleeding may occur.

b. The wearing of protective equipment in the foregoing circumstances shall be a consistent, non-discriminatory practice. Members shall not base a decision to wear protective equipment on the personal characteristics of an individual, unless the person exhibits violent tendencies.

c. In the case of a planned police operation, however, the above provisions will be superseded by the decision of the official in charge as to what protective equipment may be worn by members under his/her supervision. (See Section C under "Applicability")

3. Restrictions on Wearing of Protective Equipment.

a. The term "appropriate protective equipment" means only those items of equipment that are necessary to protect the particular areas of the body that will likely come into contact with body fluids or with unsanitary, hazardous, or infectious conditions.

b. The use of particular items of protective equipment must address the risk involved for members according to their functions at a scene or during an operation.

c. Other than those circumstances described above and unpredictable situations where the use of protective equipment is appropriate and reasonable as a precaution against exposure to body fluids and unsanitary, hazardous, or infectious conditions, members shall not wear protective equipment.

B. Hygiene and Cleaning.

Good personal hygiene, prompt, sanitary cleaning practices, and the proper medical care for and attention to cuts, sores, and skin conditions on one's own body, particularly the hands,. are the most important preventive measure for reducing the possibility of contracting a communicable disease through contact with body fluids. The Department therefore advocates that members:

1. Wash their hands or other affected skin thoroughly with soap and water after contact with body fluids. Careful hand washing is probably the most effective method of preventing the spread of infection, and alcohol preps are provided in each department vehicle as an interim preventive cleaning procedure.

2. Properly treat and cover cuts, sores, and skin conditions in order to avoid direct contact with body fluids. Such members shall be particularly careful in evaluating their personal need for protective equipment.

3. Use water to flush the eyes thoroughly or to rise the mouth amply if blood or other body fluids have splashed into the eyes or mouth.

4. Refer to the attached publication by the D.C. commission of Public Health, entitled "Guidelines for Handling Body Fluids," when questions arise as to cleaning procedures when members come into contact with body fluids (Attachment A).

C. Education.

1. Since members regularly come into contact with unsanitary, infectious, and other hazardous situations, it is imperative that they know the dangers they face and how to reduce the risks involved in these hazards.

2. In that light, the Department espouses the concept that the education of its personnel is the most effective means of dispelling misconceptions and fears, and commits itself to providing information that will enable members to carry out their responsibilities confidently, safely, and effectively.

3. The Department will therefore pursue a course of education and information dissemination on communicable diseases in cooperation with the Commission of Public Health and through the periodic issuance of publications to the force.

APPLICABILITY

A. To Members Who Process Crime Scenes.

With regard to processing crime scenes, the policy shall specifically apply to members assigned to:

1. The Crime Scene Examination Section, Identification and Records Division;

2. The Police Districts' Crime Scene Search Sections;

3. Homicide Branch, Criminal Investigations Division (CID)

4. Sex Offense Branch, CID; and

5. Any other unit that has occasion to be involved in the processing of scenes or handling situations where body fluids and/or contaminated materials are present.

B. To Situations and Persons.

1. Members should balance precaution with reasonableness when handling situations where body fluids are present and when exercising their option to wear protective equipment.

a. I am primarily concerned that our members are properly and reasonably protected from infections brought on by communicable diseases and unsanitary conditions. To this end, protection have been provided, and I believe they meet the needs of our members. I am also concerned, however, that we meet our responsibilities to the public by consistently providing a professional, measured response to problems that confront law enforcement, in general, and the Metropolitan Police Department, in particular. To this end, the standards established in this order focus on reasonably addressing the problems encountered in dealing with communicable disease and unsanitary conditions, and preventing abuses that tend to feed misconceptions and fears.

b. Members should be aware that the risk of contracting a communicable disease during the performance of duty is highly unlikely. This is evidenced by the face that transmission of a communicable disease from an occupational exposure is very rare among law enforcement, fire and rescue, and emergency medical personnel.

c. Members should also understand that the wearing of protective equipment conjures up certain negative connotations. The decision to wear particular items

of equipment must be based on the standards established in this order, as well as a consideration of its spirit and intent, as stated in the purpose. Unreasonable applications of the broader standards set forth in the order will not be tolerated. The wearing of equipment that is excessive and not likely to address a particular risk will similarly not be tolerated.

2. Members, especially field personnel, will approach many situations not knowing what they will encounter and therefore will on occasion not be protected with suitable protective equipment when they begin dealing with persons who are bleeding or excreting other body fluids. In the face of this kind of dilemma, however, members shall:

   a. Not shirk their responsibilities to protect life, preserve the peace, arrest criminal offenders, and perform their police duties generally; and

   b. If contact with body fluids has been made, be alert to the need for the prompt cleaning of affected body areas, once the member can be temporarily relieved of the assignment. Officials should take notice of a member who has been involved in blood or other body fluids and provide for his/her temporary relief as soon as possible to effect such cleaning.

C. To Planned Operations.

In planned operations, such as demonstrations, raids, or the service of warrants generally, the official in charge of the operation shall:

1. Consider the type of situation, and the conditions that are likely to exist in the particular situation, in determining what, if any, protective equipment should be utilized;

2. In determining the necessity for wearing or having available specific items for the operation, ensure that the selected items of equipment are consistent with the standards that are contained in this order for wearing such equipment; and

3. Be prepared to justify the reason why the selected equipment was chosen.

D. By Examples.

Below are some examples of situations and how they should be addressed:

1. In picking up a blood-stained knife from the ground as evidence, and officer should wear only the regular disposable gloves since only the hands should come into contact with the knife. In this case only the hands need to be protected. Most passive situations involving crime scenes and individuals in which body fluids are present will require the wearing of regular disposable gloves only.

2. When processing a scene where a large quantity of blood is present, it may be necessary for a crime scene search officer to wear rubber gloves and a jumpsuit in order to prevent the blood from splashing into the mucous membranes of the member's eyes and mouth.

3. The handling of a combative prisoner who is bleeding or has open sores may require the wearing of rubber gloves and a jumpsuit in order to avoid contact with the blood or other body fluid.

4. Evidence technicians should wear masks and goggles when there is danger of inhaling chemicals, powders, or other particulate matter, or of any of these substances entering the eyes.

5. Members maintaining security over a crime scene which contains foul odors may wear a mask to repel the odors.

6. In searching a vehicle, members should use extra precaution when reaching with their hands into areas hidden from view. Rubber gloves should be worn, and a flashlight should serve as a guide for dark areas.

7. Upon receipt of a radio call for a large fight in profess, members may put on rubber gloves when they expect that they may become involved in altercations on the scene. The purpose of the gloves is to prevent blood from a subject involved in an altercation from coming into contact with abrasions on the member's hands, which might be caused during the altercation. In an incident of this kind it must be emphasized that the risk of acquiring a serious communicable disease through such contact is extraordinary low.

8. In executing search warrants in drug-related cases where contact with dangerous chemicals or paraphernalia may occur, members should wear rubber gloves to avoid burns and reduce the risk of cuts or punctures.

9. At the scene of a serious traffic accident where there are large amounts of blood and other hazards, such as glass and debris, members should wear rubber gloves and a jumpsuit if there is going to be significant and involved contact with bleeding victims.

10. Searching prisoners with regular disposable gloves is a long established practice that will remain an option for members. However, because of the hazards involved in drug-related cases, such as needle sticks, special care should be taken in searching such prisoners. If a member believes that a prisoner has a syringe on his person, he/she should carefully search with rubber gloves do not have the same tactile qualities as the regular disposable gloves and the member cannot be assured that a thorough search has been performed.

## PROTECTIVE EQUIPMENT

A. Protective Equipment

1. Protective Equipment Kits shall consist of:

   a. A mask.

      The main purposes of the mask are:

      (1) To protect a member from inhaling or ingesting chemicals, powders, or other particulate matter, and from being splashed with blood or other body fluids; and

      (2) To repel foul odors.

   b. An apron.

      The main purpose of the apron is to prevent a member's clothing from becoming soiled or splashed with blood or body fluids.

   c. A jumpsuit.

      The main purpose of the jumpsuit is to prevent a member from coming into general contact with large amounts of blood or body fluids, or in having to handle a combative prisoner who is significantly bleeding or covered with blood or other body fluids, or has numerous open sores on his/her person.

d. Two types of gloves:

(1) Regular disposable gloves.

The main purpose of the regular disposable gloves is to prevent the member from coming into contact, with his hands, with blood and other body fluids, and unsanitary, hazardous, and possibly infectious conditions.

(2) Rubber gloves.

The main purposes of the rubber gloves are:

(a) To prevent contact with significant quantities of blood or other body fluids; and

(b) To prevent abrasions and reduce the risk of punctures, in cases where an altercation is likely, as previously described, or when dealing with hazardous situations, such as searching in areas hidden from view.

e. Alcohol preps.

The main purpose of the alcohol preps is to provide members with an immediately available cleaning agent when contact is made with blood or other body fluids or unsanitary conditions. However, affected areas should be properly washed with soap and water as soon as possible after the contact has been made.

f. Goggles.

The main purpose of the goggles is to prevent blood or other body fluids and chemicals, powder, or other particulate matter from getting into the eyes.

g. A sealable five-gallon container.

This container houses all the items in the kit.

2. All the items in the Protective Equipment Kit, except the rubber gloves and goggles, are disposable.

3. All items of protective equipment shall be issued by the Department and are the only items which may be carried or used by members.

B. Protective Equipment Required In Vehicles and Issued to Members.

1. Protective Equipment Kits shall be required equipment in all vehicles assigned to:

a. The Crime Scene Examination Section;

b. The Crime Scene Search Sections;

c. The Homicide Branch;

d. The Sex Offense Branch; and

e. Lieutenants and Sergeants in the Field Operations Bureau and the Morals Division.

2. All other police vehicles shall be equipped with:

   a. A box of regular disposable gloves; and

   b. A box of alcohol preps.

3. Each member assigned to a patrol district, the Special Operations Division, and the Morals Division, and who routinely performs field duties, shall be issued a pair of rubber gloves for his/her use.

   a. These rubber gloves are not disposable.

   b. They should be cleaned according to the instructions provided in Attachment A, and kept for re-use.

   c. They may only be discarded if they tear or become excessively discolored.

C. Protective Equipment Required in Stations.

All stations that have booking facilities and the units within the Identification and Records Division that process prisoners and evidence shall maintain, in a location readily available for immediate use at any time of day:

1. Three (3) protective equipment kits;

2. A supply of individual protective equipment items necessary for handling situations where body fluids are present; and

3. A container of bleach.

D. Protective Equipment Required in Special Circumstances.

1. In special circumstances, such as a planned police operation, the official in charge of the operation shall ensure that an adequate supply of appropriate protective equipment items are obtained for use in the operation.

2. In special circumstances, when the availability or wearing of protective equipment is determined to be appropriate, the official in charge of the operation is authorized to equip involved members and vehicles with appropriate protective equipment.

E. Issuance of Protective Equipment Kits and Separate Items.

1. Protective Equipment Kits and individual items shall be ordered through normal supply channels.

2. In the event that the Property Division is closed and there is an immediate need for certain protective equipment items, a request for the items may be made directly to the Crime Scene Examination Section.

F. Disposing of Protective Equipment

1. When disposable protective equipment items are used, they shall be discarded in a plastic bag which shall be sealed.

2. The sealed bag shall then be placed in a second plastic bag which shall also be sealed.

3. The sealed, double bag shall then be disposed of routinely.

G. Review of Protective Equipment by the Uniform and Equipment Board.

The Uniform and Equipment Board shall:

1. Maintain a continuing review of protective equipment to ensure that the items the Department utilizes adequately protect our members and are cost-effective.

2. Be responsible for recommending to the Chief of Police any changes in the items which compose the Protective Equipment Kit.

The City of Newton, Kansas

Employer Task Force on AIDS

# Policies and Procedures

# AIDS in the Work Place

Adopted by the City of Newton
Board of Commissioners

July 20, 1988

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A. Policies and Procedures Regarding AIDS--Introduction

It is the policy of the City of Newton to provide equal opportunities to all employees without regard to handicap. Because AIDS (acquired immune deficiency syndrome) and AIDS related conditions have created new medical dilemmas, the City of Newton will work with the Harvey County Health Department to remain current concerning the latest guidelines and recommendations of the Center for Disease Control in responding to the work related problems which may be caused by the virus.

The city understands that most employees with disabilities, medical handicaps or life-threatening illnesses such as cancer or AIDS, benefit greatly from the normal routines of daily life. Continued employment of valued, productive employees helps the organization as well as the individual.

B. Guidelines for Employment Decisions

The following are general guidelines for officials, supervisors and employees in making employment decisions involving persons with AIDS, ARC or sero-positivity. The city will review each AIDS related situation on an individual basis and--when it is in the best interest of the city--may take action based on prudent administrative, compelling medical and/or public health reasons.

1. All officials, supervisors and employees are expected to perform their duties and to carry out their responsibilities without regard to another person's AIDS status, except when there are compelling medical and/or public health reasons.

2. Employees with AIDS, ARC or SP will be provided equal employment opportunity with respect to placement, upgrading, transfer, demotions, promotions, terms and conditions of employment, pay and compensation, training, layoff, termination or re-instatement except for compelling medical and/or public health reasons.

3. Existing City of Newton personnel policies and procedures shall govern AIDS related situations with respect to job assignments, drug testing, confidentiality, disclosure, leaves of absence and disciplinary action, except for compelling medical and/or public health reasons.

4. In case of a possible AIDS related work incident, the individual shall contact his or her supervisor or department head immediately. An AIDS related work incident is an incident involving significant exposure to blood, semen or other body fluids contaminated with blood (see definition section). The supervisor and/or department head shall carefully follow procedures for reporting an AIDS related work incident as prescribed below.

C. Reporting of an AIDS Related Work Incident

The City of Newton officials and employees shall comply with the following procedures when reporting an AIDS related work incident:

1. Immediately make a written report to the city manager through the personnel director on the designated forms giving details of the incident and the suspected significant exposure, taking care to follow the directions provided on the form.

2. Immediately refer the employee to the personnel director to arrange counseling from the Harvey County Health Department or another expert in the medical community. Following counseling, the employee shall be given the option of initiating the series of HIV tests at the Harvey County Health Department, or an alternative testing site as approved by the city manager.

D. Exposure Categories

Category I. Tasks That Involve Exposure to Blood, Body Fluids or Tissues. All procedures or other job-related tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids, or tissues, or a potential for spills or splashes of them, are Category 1 tasks. Use of appropriate protective measures should be required for every employee engaged in Category 1 tasks.

Category II. Tasks That Involve No Exposure to Blood, Body Fluids, or Tissues But Employment May Require Performing Unplanned Category I Tasks. The normal work routine involves no exposure to blood, body fluids, or tissues, but exposure or potential exposure may be required as a condition of employment. Appropriate protective measures should be readily available to every employee engaged in Category II tasks.

Category III. Tasks That Involve no Exposure to Blood, Body Fluids, or Tissues, and Category I Tasks Which Are Not a Condition of Employment.

E. Blood and Body Fluids Precautions

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eye wear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.

2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.

3. All health-care workers should take precautions to prevent injuries caused by needles and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needle stick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.

4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.

5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy,

the infant is at risk of infection resulting from perinatal transmission. Because of this, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

F. Personal Protective Equipment

For workers performing Category I tasks, a required minimum array of protective clothing or equipment should be specified by pertinent SOP's. All Category I tasks do not involve the same type or degree of risk, and therefore all do not require the same kind or extent of protection. Specific combinations of clothing and equipment must be tailored to specific tasks. Minimum levels of protection for Category I tasks in most cases would include use of appropriate gloves. If there is the potential for splashes, protective eyewear or face shields should be worn. Paramedics responding to an auto accident might protect against cuts on metal and glass by wearing gloves or gauntlets that are both puncture-resistant and impervious to blood. If the conditions of exposure include the potential for clothing becoming soaked with blood, protective outer garments such as impervious coveralls should be worn.

For workers performing Category II tasks, there should be ready access to appropriate protective equipment, e.g., gloves, protective eye wear, or surgical masks, specified in pertinent SOPs. Workers performing Category II tasks need not be wearing protective equipment, but they should be prepared to put on appropriate protective garb on short notice.

G. Housekeeping and Other Environmental Considerations

When a large spill of blood or body fluids is discovered, the area should be blocked off. During the cleaning procedure, it is essential that the custodial worker wears gloves. A mask may be used but is not required. When the spill hits the floor, tiny droplets may splash up into the air for a brief time. So, if a mask is not worn, the mouth should be kept closed when working over the spill.

As quickly as possible, the spill should be sprayed with a disinfectant. The Centers for Disease Control recommends a 10% solution of bleach and water as the primary surface disinfectant to inactivate the AIDS virus. However, full-strength rubbing alcohol may be used to disinfect spills on carpet to avoid bleaching the carpet.

The disinfectant should be sprayed thoroughly over the infected area and allowed to settle down on it. Direct spraying or pouring may cause the infected material to

aerosolize. After spraying, the spill should not be disturbed until after the disinfectant has had time to settle and soak in to inactivate the virus. This will take 15-30 minutes, depending on the thickness of the spill. Of course, if there is a danger of the spill spreading, it must be cleaned up as quickly as possible.

After the disinfectant has had time to take effect, sand or some other absorbent material may be lightly sprinkled over the spill to make it easier to clean up. Powders specially designed to deodorize and absorb liquid spills are available from local purveyors.

The spill can be placed in a heavy-duty (or double) plastic bag using a dust pan and disposable rags. All absorbent materials used must be discarded. The bag must be tightly sealed and disposed of in the usual manner. Sharp objects, such as broken glass must be placed in a puncture-proof container, sealed and disposed of. Final mop-up of the area can be performed using normal rest room cleaning procedures.

Contaminated cleaning utensils, including the gloves and anything touched during the clean-up procedure, should be disinfected immediately after the cleanup is complete, using the approved disinfectant. After the gloves are removed, the custodial workers should wash their hands thoroughly. Gloves should never be considered a substitute for washing hands.